University of Alberta

The Hyperactive State: The History of Attention-Deficit/Hyperactivity Disorder (ADHD) and American Psychiatry, 1957-1980

by

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Abstract

Attention-Deficit/Hyperactivity Disorder is currently the most commonly diagnosed childhood psychiatric disorder in North America. In this thesis I investigate how American psychiatrists came to understand hyperactivity during the period 1957-1980. I investigate how hyperactivity emerged from being an obscure and rarely studied condition during the 1950s to being a seemingly ubiquitous childhood affliction by 1980. I also explain why the disorder came to be understood in biological terms and best treated with pharmaceuticals.

I argue that increased psychiatric interest in hyperactivity during the 1960s followed unprecedented concern about the mental health of children and growing pressure for young Americans to achieve high academic standards. I also contend that the biological approach to hyperactivity became predominant not because it was scientifically superior to that of psychoanalysis and social psychiatry, but rather because it was less time-consuming, complicated, and expensive.

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Introduction

In a 2002 report by the American Center for Disease Control and Prevention it was announced that at least seven percent of all elementary school children during 1997-1998 had been diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD).[1] In a typical classroom of thirty pupils this would mean that at least two students would have been diagnosed with the disorder. Although these statistics amount to millions of children, they do not account for pre-school and kindergarten children who had been diagnosed prior to entering elementary school, nor the adolescents and increasing numbers of adults who are diagnosed with ADHD.

Most mental health professionals believe that ADHD is a neurological impairment that runs in families and is characterized by impulsivity, hyperactivity, distractibility, defiance, and aggression.[2] Although psychiatrists are hesitant to pinpoint the exact etiology of the disorder, they usually suspect either genetics or brain trauma, caused by difficulties during pregnancy, prenatal exposure to alcohol and tobacco, or postnatal injury to the prefrontal regions of the brain. They state that genetics or brain trauma are responsible for causing the impairments in the executive functioning of the nervous system that underlie ADHD symptoms. Executive function refers to a wide range of central control processes in the brain that activate, integrate, and manage other brain functions.[3] The treatment most commonly used for those diagnosed with ADHD is

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[1] P.N. Pastor and C.N. Reuben, "Attention Deficit Disorder and Learning Disability: United States, 1997-1998," Washington: National Center for Health Statistics, *Vital Health Statistics*, 10 (No. 206, 2002), 3.
[2] Barbara D. Ingersoll, *Daredevils and Daydreamers: New Perspectives on Attention-Deficit/Hyperactivity Disorder* (New York: Doubleday, 1998), 1-22; Paul H. Wender, *ADHD: Attention-Deficit Hyperactivity Disorder in Children and Adults* (Oxford: Oxford University Press, 2000), 34-55.
[3] C. Dendy, "5 Components of Executive Function," *Attention!* (February 2002), 26-31.

pharmacotherapy and, specifically, stimulant drugs such as methylphenidate, otherwise known by its trademark name, Ritalin.

While many people may be somewhat familiar with ADHD through friends and relatives with children, the news media, and even television comedies such as *The Simpsons*, there is much more to the disorder than is usually presented. For those diagnosed and their families, ADHD is thought to represent a forecast of potential problems such as substance abuse, criminal behaviour, more serious mental health ailments such as depression and schizophrenia, and perhaps most troubling, a legacy of untapped academic, social, and vocational potential. For the mental health industry, consisting of pharmaceutical companies, psychiatrists, hospitals, clinics, and others involved in mental health care, referrals for ADHD account for between thirty and fifty percent of all childhood mental health referrals.[4] These referrals not only provide the mental health industry with a substantial market for pharmacotherapy, they also establish a pattern, early in a person's life, of seeking medical treatment to manage mental health problems.

My interest in ADHD stems from my work as a career advisor for troubled youth. One of my primary objectives in dealing with my clients was to identify and address the key problems that had interfered with their academic performance. During my training I was instructed to be cognizant of "hidden barriers" that, left untreated, would continue to impede the individual's academic and occupational success. The most prevalent and nefarious of these barriers was ADHD. Armed with a checklist to identify potential

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[4] Peter S. Jenson and the MTA Group, "Treatments: The Case of the MTA Study," in Seija Sandberg (ed.), *Hyperactivity and Attention Deficit Disorders of Childhood* (Second Edition; Cambridge: Cambridge

sufferers, I interviewed hundreds of young people and found to my surprise that a large percentage of my clients seemed to exhibit the symptoms of ADHD, specifically, impulsive, distractible, hyperactive, aggressive, and defiant behaviour. Not being a psychologist, I would refer my clients for a neuro-psychological assessment where they were summarily given an official diagnosis and provided with a list of general practitioners who could start them on a course of pharmacotherapy.

Four aspects of this pattern began to concern me. First, the numbers of young people given an ADHD diagnosis seemed remarkably high. Not only did it seem like every youth who had experienced academic trouble was a potential ADHD sufferer, but many of my family members, most of my friends, and I myself apparently exhibited an alarming number of ADHD symptoms. Second, an ADHD diagnosis was perceived as being a more important factor in poor school performance than other detrimental conditions, such as family breakdown, abusive relationships, and substance abuse. In fact, it has often been suggested that these problems are likely caused by ADHD.[5] Third, it struck me that ubiquitous ADHD diagnoses expunged an individual and his or her family of all responsibility for past or subsequent failures in life. An ADHD diagnosis seemingly swept away one's personal accountability for bad relationship decisions, lacklustre academic efforts, laziness on the job, and morally repugnant behaviour. In short, "it wasn't me, it was the ADHD!" Finally, I began to question the notion underlying ADHD that hyperactivity, impulsivity, distractibility, defiance, and aggression were always pathological behaviours. Under a different light these same characteristics

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University Press, 2002), 436.
[5] Wender, *ADHD*, 65-67.

may be perceived to be enthusiasm, creativity, adventurousness, courage, and determination, virtues that help societies adapt to changing circumstances and solve difficult problems and assist individuals to defy injustice and defend their beliefs. Was it wise to medicate these "symptoms" out of existence?

In order to resolve these issues for myself and develop a more sophisticated understanding of the disorder, I decided to view ADHD from a different and, specifically, historical perspective. Under what conditions did ADHD emerge as a major childhood and, increasingly, adulthood disorder? Why was it understood in the way it was, as a neurological impairment? Despite the prominent status of ADHD in popular, educational, and medical literature from the 1960s onward, I was surprised to find that no historical work had been done to analyze the disorder's origins and answer these sorts of questions. In the attempt to fill some of this lacuna, I decided to investigate how American psychiatry in particular came to understand and deal with ADHD, or more specifically, hyperactivity, the term that has been used most consistently over the past fifty years to describe what is now called ADHD. I concentrated on the years 1957-1980 because these were the years during which the intense debates within psychiatry over hyperactivity raged. These years are also significant because during this period American psychiatry evolved from being a profession dominated by psychoanalytic theory to one firmly rooted in biological psychiatry, a transition that philosopher of science Thomas S. Kuhn would call a "paradigm shift."[6]

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[6] Thomas S. Kuhn, *The Structure of Scientific Revolutions* (Third Edition; Chicago: University of Chicago Press, 1996).

Source material for this thesis consisted of not only professional articles, but also letters to the editor, book reviews, and position statements found primarily in the two most relevant psychiatric journals of the time, the *American Journal of Psychiatry*, the voice of the American Psychiatric Association, and the *Journal of the American Academy of Child Psychiatry*, the voice of the American Academy of Child Psychiatry. These journals were chosen because they reflected the most authoritative voices of both general psychiatry and child psychiatry in the United States during the period 1957-1980. Three protagonists emerge from the pages of these journals, representing the most influential and prominent branches of psychiatry during the period. These branches included psychoanalytic psychiatry, which dominated American psychiatry during the 1950s and early 1960s, social psychiatry, which challenged the hegemony of psychoanalysis in the 1960s, and biological psychiatry, which eventually came to dominate American psychiatry by the late 1970s.[7]

This research into ADHD and American psychiatry shows that although it is widely believed that ADHD is a neurological impairment, the origins of the disorder and the history of how it has been understood by psychiatrists have been securely rooted in the social environment both within and outside of their profession. Psychiatric interest in the symptoms of ADHD during the 1960s emerged out of American preoccupation with children (the baby boomers), their education, and the perception that they were falling behind their Soviet counterparts in academic achievement. Hyperactivity, the chief

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[7] The terms employed to describe these psychiatric fields have been used because they reflect the most common classifications found in contemporary psychiatric literature. Historians of psychiatry who have examined this period have also used these terms to describe the divisions in psychiatry. Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton, New Jersey: Princeton

symptom of ADHD, was pathologized because it interfered with the type of rigorous, doctrinarian, and scientifically based education that many American leaders desired for American children. Correspondingly, President Kennedy's commitment to improving the mental health of Americans, and especially American children, spurred psychiatrists to work towards the healthy mental development of children in an effort to solve the nation's psychiatric problems, but also to finally legitimize their profession as an authoritative medical science, an ambition identified by medical historian Charles E. Rosenberg.[8] Rosenberg argues that the difficulty in defining psychiatry's role within society, medicine, and the profession itself has contributed to the profession's problems in attaining the respect and stability it desires.[9] Therefore, psychiatrists have characteristically looked for opportunities to boost the profile and reputation of their profession. Historians Roy Porter and Mark S. Micale have also demonstrated how the sporadic and meandering development of psychiatric theory, as opposed to more progressive and unilinear development perceived in other medical fields, has complicated historical interpretations of the profession's legitimacy.[10] By addressing hyperactivity in children, psychiatrists tapped into a problem perceived to be of increasing significance and, subsequently, a vast market of potential patients. As a result, the ambitions of psychiatry as a profession were served by its attention to hyperactivity.

University Press, 1991), 403-404.

[8] Charles E. Rosenberg, *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge: Cambridge University Press, 1992), 245-257.

[9] Rosenberg, *Explaining Epidemics*, 246.

[10] Roy Porter and Mark S. Micale, "Introduction: Reflections on Psychiatry and Its Histories," in Roy Porter and Mark S. Micale (eds.) *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994), 5.

Although psychiatrists were enticed to study hyperactivity during the 1960s, the current biological understanding of the disorder, that it is caused by a neurological impairment and best treated with stimulant medication, did not become authoritative until the late 1970s. Instead, biological psychiatrists competed fiercely with psychoanalysts and social psychiatrists to develop the dominant explanation for the disorder. Moreover, the acceptance of a purely biological explanation for and treatment of hyperactivity during the late 1970s was neither inevitable, nor desirable. Instead of drawing comprehensive conclusions that were based on the findings of biological psychiatry, social psychiatry, and psychoanalysis, each field jostled with each other to produce an account of the disorder that would eclipse that of the other. The very fact that the fields refused to collaborate or draw cross-disciplinary conclusions about hyperactivity undermined the understanding of the disorder, why it was thought to be such a serious problem, and whether or not it should be treated, let alone how. Biological psychiatry emerged victorious in this ideological competition not so much because its approach to hyperactivity was more scientifically valid or accurate, but rather because it was less expensive, time consuming, and complicated than that of social or psychoanalytic psychiatry.

The history of American psychiatric experience with hyperactivity during 1957-1980 provides an excellent window through which to view the evolution of American psychiatry from a field dominated by Freudian psychoanalysis to one firmly entrenched in biomedical theory. In using the term "evolution" I do not wish to imply that biological psychiatry is somehow superior to psychoanalytic or any other psychiatric field. Rather, I

contend that the biological psychiatry that emerged during the 1960s and 1970s, one of many mutations of psychiatry during its history, best fit the circumstances thrust upon it during that period.

The biological turn in American psychiatry during the 1970s was not the first such shift in the history of American psychiatry. Rather, the profession experienced a similar move to neuro-physiological explanations of mental illness a few decades before, during the 1920s and 1930s. While this earlier drift has been described by prominent historians of psychiatry such as Gerald N. Grob and Elizabeth Lunbeck,[11] perhaps the most instructive interpretation of the period for this study is historian Jack D. Pressman's 1998 work *Last Resort: Psychosurgery and the Limits of Medicine*.[12] Drawing on Rosenberg's contention that medicine and therapeutics operate within a cultural context,[13] Pressman argues that the use of lobotomies between the mid-1930s and mid-1950s was consistent with the atmosphere of crisis and change in which psychiatry operated during this period.[14] Pressman's description of how psychiatrist Adolph Meyer's vision of a multidisciplinary, far-reaching, and influential American psychiatric profession faltered during the 1940s is an essential element to understanding how American psychiatry reacted to hyperactivity. The flight of European psychoanalysts from Nazi Germany to the United States in the 1930s created a group of psychiatrists whose views were

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[11] Gerald N. Grob, *The Inner World of American Psychiatry, 1890-1940: Selected Correspondence* (New Brunswick, New Jersey: Rutgers University Press, 1985); Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994); Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, New Jersey: Princeton University Press, 1994).

[12] Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998).

[13] Rosenberg, *Explaining Epidemics*, 10-11.

[14] Pressman, *Last Resort*, 8-9.

diametrically opposed to those of the more physiologically minded American psychiatrists.[15] The rift between the two camps grew over issues such as the use of psychosurgery, the political control of the American Psychiatric Association, and most importantly, the direction of American psychiatry.[16] The resulting bitter feelings between the competing fields make it understandable that when the problem of hyperactivity arose a little over a decade later, American psychiatrists were loathe to embark upon a Meyerian compromise. The schism between psychoanalysis and biological psychiatry, which would extend to social psychiatry in the 1960s, therefore, affected how hyperactivity was to be approached and dealt with by American psychiatry as a whole. Each faction set off to solve the problem of hyperactivity independently of one another, leading to three drastically different solutions.

American psychiatry also had to face conflict emanating from outside its profession by the 1950s and 1960s. Not only was the public increasingly repulsed by psychosurgery,[17] but the conditions and the very therapeutic effectiveness of state psychiatric hospitals were being strongly questioned by many, most notably, Erving Goffman in his 1961 study, *Asylums*.[18] Moreover, the very notion of psychiatry was being strongly questioned by both academics and radical psychiatrists. While French philosopher Michel Foucault attacked psychiatry as being an agent of social control, libertarian psychiatrist Thomas Szasz questioned the very existence of mental illness in

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[15] Pressman, *Last Resort*, 365-366.
[16] Pressman, *Last Resort*, 366-368
[17] Pressman, *Last Resort*, 402.
[18] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, New York: Anchor Books, 1961). Grob notes that psychiatry increasingly oriented itself away from the large psychiatric institutions during the first half of the twentieth century. Grob, *The Mad Among Us*.

the pages of the *American Journal of Psychiatry* on a regular basis.[19] This external pressure encouraged each branch of American psychiatry to be on the lookout for opportunities that would put it back in the public's trust. Hyperactivity would soon represent such an opportunity.

The dynamics of how psychiatrists perceived and took advantage of hyperactivity as a way of achieving their professional ambitions are an essential focus of this thesis. Pressman uses the analogy of a lock and key to describe the relationship between perceived psychiatric problem and acceptable cure, the lock representing the problem that psychiatrists are meant to solve and the key being the therapeutic measure used to solve it. Since, as Pressman argues, the psychiatric problems are culturally, as well as biologically, relative, they change as society does. When this happens, therefore, a different key, or therapeutic measure, is needed to address the changed lock, or problem.[20] Moreover, the psychiatrist's success in solving psychiatric problems is dependent not only on physiological evidence, but the public perception that a positive solution has been found.[21] The success of psychosurgery between 1935 and 1955 is a testament not to psychiatry's susceptibility to adopting shocking therapeutics, but instead its ability to meet a perceived need.[22]

Pressman's lock and key analogy can also frame effectively the history of American psychiatry and hyperactivity. Psychiatrists, influenced by external political, economic, and cultural factors as well as professional ambitions to grow as an

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[19] Michel Foucault, *Madness and Civilization* (New York: Pantheon Books, 1965); Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper and Row, 1974).
[20] Pressman, *Last Resort*, 15.
[21] Pressman, *Last Resort*, 15.

authoritative and powerful medical science, viewed hyperactivity as both a problem that needed to be solved and a means to their own objectives. Similarly, biological psychiatry's success in creating a key that unlocked the problem of hyperactivity, namely, psycho-stimulants, was dependent upon its ability to correctly perceive the needs of the American public as well as its skill in reorienting psychiatry towards mainstream medicine. The social psychiatric and psychoanalytical solutions to hyperactivity, on the other hand, moved psychiatry further away from mainstream medicine, a move that undermined the profession's quest for scientific authority and legitimacy. Moreover, social psychiatrists and psychoanalysts also misread the cultural context into which their solutions for hyperactivity had to operate. Therefore, their solutions, although just as theoretically legitimate as those of biological psychiatrists, failed to meet the expectations and needs of both their fellow psychiatrists and the American public.

Histories written about Post-Traumatic Stress Disorder (PTSD), Multiple Personality Disorder (MPD), and anorexia nervosa, conditions that became widespread during the same period as hyperactivity, have also provided instructive lessons about how social factors affect the work psychiatrists do to identify and treat mental illness. Anthropologist Allan Young's 1995 study, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, for example, demonstrates how the activism of American Vietnam War veterans was required to encourage psychiatrists to take an interest in the array of symptoms the veterans were presenting.[23] This is despite the fact that the

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[22] Pressman, *Last Resort*, 16.

[23] Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995). Sociologists Herb Kutchins and Stuart A. Kirk have also described how Vietnam veterans successfully lobbied the editors of *DSM-III* to have PTSD included in their authoritative manual.

symptoms of PTSD have been identified in literature as diverse and as ancient as *The Epic of Gilgamesh* and *Henry IV, Part I*, and physicians were researching and treating PTSD-like symptoms in soldiers following the American Civil War, both World Wars, and train wrecks during the nineteenth century.[24] Young argues that in this way, PTSD becomes an amalgamation of practices, techniques, and narratives that are diagnosed, studied, treated, and represented by both medical and non-medical actors to serve their own particular interests.[25]

In suggesting that new medical ideas are only received favourably when they correspond to the pervasive political and intellectual climate, Young is following up on philosopher of science Ludwik Fleck's concept of "thought style" in his *Genesis and Development of a Scientific Fact*, the work from which Young's title phrase, *Harmony of Illusions*, is borrowed.[26] Pressman also makes use of "Fleck's framework for understanding the evolution of scientific concepts" in describing how psychosurgery was adopted by psychiatrists.[27] Fleck states that all thoughts, including those that are scientific, are constrained by the prevailing "thought style" that governs which theories become authoritative scientific facts.[28] Fleck's work on the history of syphilis demonstrates how the thoughts and resulting facts about the collection of symptoms

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Herb Kutchins and Stuart A. Kirk, *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders* (New York: The Free Press, 1997), 100-125.

[24] Young, *Harmony*, 5. Lawyer and historian Eric T. Dean has also argued that Civil War veterans suffered from similar, possibly more intense, symptoms of post-traumatic stress. Eric T. Dean, Jr., *Shook Over Hell: Post-Traumatic Stress, Vietnam and the Civil War* (Cambridge, Massachusetts: Harvard University Press, 1997).

[25] Young, *The Harmony of Illusions*, 5.

[26] Ludwik Fleck, *Genesis and Development of a Scientific Fact* (Chicago: The University of Chicago Press, 1979).

[27] Pressman, *Last Resort*, 520.

[28] Fleck, *Genesis*, 98.

which we identify as syphilis have varied significantly throughout the centuries, ranging from being a moral scourge when religious thought was authoritative to being a venereal disease caused not by immoral behaviour, but by a bacterium.

In a similar way historian Joan Jacob Brumberg's 1988 work, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease*, explores how explanations of female fasting throughout history have also had both religious and medical overtones.[29] Brumberg also explores the pathologization of behaviour in asking why anorexia nervosa, an expression of female holiness in the Middle Ages and Renaissance and "an isolated and idiosyncratic disorder" in the nineteenth century, became a widespread and frightening phenomenon in the 1970s.[30] By treating the symptoms of anorexia nervosa as a veritable biological entity, while simultaneously stressing cultural factors that have made these symptoms a disease, Brumberg presents what historian Mark Micale has subsequently called a "sociosomatic perspective" in his 1995 historiography of hysteria, *Approaching Hysteria: Disease and Its Interpretations*.[31] This approach, which is quite similar to that of Rosenberg,[32] engages the historian in analyzing both the external (social) and internal (biological) etiologies of disease and results in a pluralistic interpretation of mental illness. Like Pressman, Micale encourages historians to write

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[29] Joan Jacob Brumberg, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease* (Cambridge, Massachusetts: Harvard University Press, 1988).
[30] Brumberg, *Fasting Girls*, 5-6.
[31] Mark S. Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton: Princeton University Press, 1995).
[32] In his essay "Framing Disease: Illness, Society, and History" Rosenberg stresses that the multifaceted nature of disease includes biological, linguistic, political, social, cultural, and interpersonal dimensions. Rosenberg, *Explaining Epidemics*, 305.

histories of disease that are focussed on both the theory and practice of medicine, a suggestion that has been heeded in this history of ADHD and American psychiatry.[33]

Philosopher Ian Hacking's 1995 study of Multiple Personality Disorder (MPD) [34] also provides some provocative ideas about pathology and mental illness that may be applied to the history of ADHD. In *Rewriting the Soul: Multiple Personality and the Sciences of Memory*, Hacking suggests that MPD originated approximately one hundred years ago, during a time when new sciences concerned with memory were evolving in an effort "to cure, help, and control the one aspect of human beings that had hitherto been outside science," namely, the soul.[35] Sciences of memory (and forgetting), ranging from psychodynamic approaches to neurochemistry and artificial intelligence, are central to MPD because it is most often thought that the disorder is caused by the repression of traumatic childhood memories, usually sexual abuse.[36] Hacking uses the term "memoro-politics" to describe how the soul is politicized, as well as to augment philosopher Michel Foucault's description of the politicization of the body and the population in general

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[33] Micale, *Approaching*, 129-139.

[34] As of *DSM IV* (1994), MPD is now referred to as "Dissociative Identity Disorder (formerly Multiple Personality Disorder)." I will use the acronym MPD in this section for reasons of brevity, but more importantly because MPD remains the more commonly used term within the popular discourse. I use ADHD in this section, instead of the somewhat more common ADD, because hyperactivity (the missing "H") is nevertheless central to most people's understanding of the term. In subsequent sections I will use the term hyperactivity because it is more historically accurate in that context. It is also important to note that while I use "MPD," philosopher Ian Hacking, whose work on MPD I refer to, refrains from using the acronym on the grounds that to do so makes a term "permanent, unquestioned." While I generally agree with Hacking's cautionary note (and tend to despise acronyms, especially those that stand for terms of which I am unaware), it should be clear that the very act of questioning the permanence of psychiatric disorders is a central feature of my investigation into the history of ADHD. Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton: Princeton University Press, 1995), 17.

[35] Hacking, *Rewriting*, 209. Hacking defines soul rather broadly, saying that it refers to the "the strange mix of aspects of a person that may be, at some time, imaged as inner." Hacking *Rewriting the Soul*, 6. To paraphrase, Hacking uses "soul" to represent the intangible, mutable, emotional, and unknowable elements of a human being.

[36] Hacking, *Rewriting the Soul*, 199.

(anatomo-politics and bio-politics, respectively).[37] He goes on to say that memoro-politics arose in the late nineteenth century along with the sciences of memory and, together, direct us to believe that objective knowledge about memory can be achieved.[38]

Therefore, the existence of MPD, a condition whose entire essence revolves around issues related to memory, and how it is created, mutated, suppressed, and reborn, is only made possible by the encroachment of science upon the territory of the soul via the sciences of memory. Nevertheless, Hacking stresses that memories of human interaction often impose present-day descriptions on the past that are based on the descriptions of others and are structured in the fashion of a narrative.[39] In other words, they are often disassociated from what actually occurred. Furthermore, Hacking suggests that there is nothing wrong with this or the false memories experienced by those with MPD, provided that they harm no one.[40] The need for a complex perspective regarding the history of ADHD and those diagnosed with it becomes especially apparent when these ideas are considered with Hacking's thoughts about dynamic nominalism.[41] Hacking's dynamic nominalism would suggest that people with ADHD emerged concurrently with the discovery of the disorder and in so doing made it possible for others to be hyperactive and distractible.[42]

The histories of the aforementioned disorders, syndromes, and diseases all provide relevant models for this investigation into the history of ADHD. This exploration of the

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[37] Hacking, *Rewriting the Soul*, 214-215.
[38] Hacking, *Rewriting the Soul*, 232-233.
[39] Hacking, *Rewriting the Soul*, 257.
[40] Hacking, *Rewriting the Soul*, 259.
[41] Ian Hacking "Making Up People," in Mario Biagioli (ed.), *Science Studies Reader* (New York: Routledge, 1999), 161-171.
[42] Hacking, "Making Up People" in *Science*, 165.

history of American psychiatry and ADHD examines both how hyperactivity emerged as a major problem and opportunity for American psychiatrists during the 1960s as well as why the solution promoted by biological psychiatrists became, by the late 1970s, the most effective way for the profession to simultaneously solve and take advantage of the problem. In order to deal with the question of why hyperactivity emerged during the 1960s, Chapter I describes the American public's deep concern with the baby boom generation, its upbringing, educational success, and prospects in leading the United States successfully through all aspects of the Cold War. I then demonstrate how the American public and political elite, especially President Kennedy, looked to psychiatry to solve the psychic problems perceived to be plaguing the United States, and especially its young people. I argue that the symptoms of ADHD, hyperactivity, distractibility, impulsivity, defiance, and aggression, were characteristic of the types of problems thought to be retarding the blossoming of the baby boom generation. Finally, I contend that American psychiatry, eager to take advantage of this opportunity to earn itself the prestige, power, and authority it desired, turned with enthusiasm to address what would become the symptoms of ADHD.

Chapter II explores how each of the most powerful branches of psychiatry, social psychiatry, psychoanalysis, and biological psychiatry, attempted to solve the problem of hyperactivity. Each is addressed in turn, starting with social psychiatry and the difficulties it faced in convincing other psychiatrists first, that its preventative, idealistic, and revolutionary solution to hyperactivity could work and second, that their approach would not undermine the authority of psychiatrists. Next Chapter I describes how

psychoanalysis, the reigning authority in American psychiatry during the 1950s and 1960s, attempted to retain control over the profession despite having a therapeutic approach to hyperactivity that was perceived to be both unscientific and impractical. Finally, I present the story of biological psychiatry and hyperactivity, arguing that the field's pragmatic and neurological approach to the disorder addressed the needs of both those affected by hyperactivity and the American psychiatric community.

By describing the history of American psychiatry and ADHD in this way, it is my goal to highlight how psychiatric knowledge is substantially influenced by social factors that exist outside of and within the psychiatric profession. These factors are clearly reflected in the way in which the psychiatric profession determines, defines, and deals with mental health problems. Knowledge of ADHD, therefore, is woefully incomplete unless the full ramifications of its social origins are taken into consideration.

Why Did Hyperactivity Emerge During the 1960s?

Although hyperactivity[43] has been a major topic in American psychiatry since the late 1960s, dominating the field of child psychiatry in particular, the issue was not perceived to be a major problem by psychiatrists less than a decade earlier. For example, in the third edition of *Child Psychiatry* (1957), a textbook written by Leo Kanner, the subject was not given a single mention due to its obscurity.[44] Commenting on the paucity of psychiatric research on hyperactivity in a 1963 article, psychiatrist and past president of the Boston Psychoanalytic Society, Gregory Rochlin stated that hyperactivity was virtually neglected by researchers and required much more study. Despite the lack of research, Rochlin, like most other psychiatrists of the early 1960s, attributed the narcissistic, hedonistic, and aggressive behaviour that he felt characterized hyperactivity to early childhood trauma and arrested superego development. He also believed that the etiology of the rarely studied behaviour was best explained by psychoanalytical theory.[45]

In marked contrast to later researchers, Rochlin noted that since active and even hyperactive behaviour in children was thought to be an indication of the type of physical development desired by American parents, teachers, and physicians, hyperactivity was often not believed to be a problem. Instead, shy and inhibited children were more likely

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[43] In this section I use the term hyperactivity to be inclusive of the other behaviours that are symptomatic of what is now ADHD: distractibility, impulsivity, defiance, and aggression. This is because these behaviours were linked with the concept of hyperactivity during this time. Although the term describes a particular behaviour, hyperactivity was, by the 1960s, a catch-all term for all of these other behaviours. Therefore, psychoanalysts, who viewed hyperactive behaviour as being primarily impulsive, would nevertheless use the term hyperactivity or hyperkinetic syndrome to describe all of the above behaviours.

[44] Leo Kanner, *Child Psychiatry* (Third Edition; Springfield, Illinois: Thomas, 1957).

[45] David E. Rochlin, "Discussion of 'Observations of Delinquent Behaviour in Very Young Children,'" by David E. Reiser, *Journal of the American Academy of Child Psychiatry*, Vol. 2 (1962), 67.

thought to be mentally disturbed.[46] In other words, parents, teachers, and physicians prized the superior physical development of children more than that of the intellect. By the Soviet launch of the *Sputnik* satellites, such values began to reverse as American politicians, educators, and physicians feared that the nation's youth lagged behind the Soviets in terms of intellectual superiority.[47] One of the results of this momentous switch was an explosion in the amount of hyperactivity research done by American psychiatrists during the 1960s.[48]

This is not to say that the symptoms resembling those presented by ADHD had been absent in children prior to the 1960s. On the contrary, impulsivity, hyperactivity, distractibility, defiance, and aggression had been identified as detrimental characteristics in children for a century, most notably in the German nursery rhyme, *Fidgety Phil*.[49] Moreover, medical journals had begun writing articles about hyperactive behaviour before the turn of the century,[50] and reports by psychiatrist Charles Bradley as early as 1937 in *The American Journal of Psychiatry* had demonstrated the efficacy of stimulants in treating hyperactivity.[51] The lack of research on hyperactivity during the late 1950s and early 1960s is made even more perplexing by evidence that child psychiatrists during the 1950s dealt most often with children who "acted out" and presented symptoms

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[46] Rochlin, "Discussion," *Journal of the American Academy of Child Psychiatry*, 67.

[47] Gerald L. Gutek, *Education in the United States: An Historical Perspective* (Englewood Cliffs. New Jersey: Prentice Hall, 1986), 275-279; Arthur S. Trace, Jr., *What Ivan Knows That Johnny Doesn't* (New York, Random House, 1961), 3.

[48] Jules Schrager, Janet Lindy, Saul Harrison, John McDermott, and Paul Wilson "The Hyperkinetic Child: An Overview of the Issues," *Journal of the American Academy of Child Psychiatry*, Vol. 5 (1966), 528. Not all psychiatrists who dealt with children would self-identify as child psychiatrists. This is partly because child psychiatry only became a specialty within psychiatry in the late 1950s and many general psychiatrists, especially those at Community Mental Health Centres, would treat both children and adults.

[49] Wender, *ADHD*, 3.

[50] Wender, *ADHD*, 3.

resembling those found in ADHD.[52] These symptoms included not only hyperactivity, which was often used as a catchall term, but also related disruptive childhood behaviours like impulsivity, distractibility, aggression, and defiance,

By the mid-1960s, however, hyperactivity was receiving a great deal of attention from psychiatrists representing psychoanalytic, biological, and social points of view, as well as allied mental health professionals, such as psychiatric social workers, psychologists, and neurologists.[53] As psychiatrists like Schrager, Lindy, Harrison, McDermott, and Wilson noted, the "mere mention of the term 'hyperkinetic syndrome' [was] guaranteed to stir up vigorous discussion in medical, psychological, social work, and educational circles."[54] Psychiatric journals like the new *Journal of the American Academy of Child Psychiatry* (founded in 1962) and established journals like the *American Journal of Psychiatry* began publishing dozens of articles on hyperactivity per year. Furthermore, by the late 1970s, five percent of American children were diagnosed with hyperkinetic syndrome (the term for hyperactivity presented in the 1968 *Diagnostic and Statistical Manual*).[55] Why did the symptoms of ADHD gain the attention of so many psychiatrists during the 1960s?

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[51] C. Keith Conners and Leon Eisenberg, "The Effects of Methylphenidate on Symptomology and Learning in Disturbed Children," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 458.

[52] Justin D. Call, "Some Problems and Challenges in the Geography of Child Psychiatry," *Journal of the American Academy of Child Psychiatry*, Vol. 15 (1976), 152. "Acting out" was a term applied to hyperactivity during the 1950s, especially by psychoanalysts. Eveoleen N. Rexford, "Introduction to the Symposium on a Developmental Approach to Problems of Acting Out," *Journal of the American Academy of Child Psychiatry*, Vol. 2 (1963), 2.

[53] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Psychiatric Academy*, 526.

[54] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Psychiatric Academy*, 528.

[55] Philip J. Graham, "Epidemiologic Perspectives on Maladaptation in Children: Neurological, Familial, and Social Factors," *Journal of the American Academy of Child Psychiatry*, Vol. 17 (1978), 200.

The answer involves the social factors from both inside and outside of the profession that affected psychiatrists and the perceptions they formed regarding children, the mental health of young Americans, and their role in preserving and protecting both children and public mental health. Indeed this chapter is primarily about how and why psychiatric perceptions about children and mental health were formed and how this helped to pathologize the behaviours characterized by ADHD. My contention is that these perceptions were at once reflective of genuine psychiatric concern about the mental health of American society, but also the psychiatrists' strong desire to place mental health at the forefront of public health policy and, therefore, solidify their profession's place as a legitimate, authoritative, and powerful medical field. In other words, the formation of psychiatric perceptions were at once formed by a mix of medical concern and professional ambition. In turn, social factors such as the American preoccupation with the baby boom, its education, mental health, and employment prospects influenced profoundly what was worthy of medical concern and how psychiatric ambition was realized. Finally, the mental health initiative brought by President Kennedy to Congress in 1963 was the crucial element required to spur psychiatrists to research disorders like hyperactivity. While not all psychiatrists shared the same perceptions about American mental health,[56] it is clear that the bulk of the profession agreed by the 1960s that the

[56] The heterogeneity of psychiatry is underscored by the presence of numerous psychiatrists in the anti-psychiatry movement, a loose consolidation of academics, former psychiatric patients, politicians, and a handful of psychiatrists who were critical of psychiatry, its practices, and the very existence of mental illness. Anti-psychiatrists and so-called radical psychiatrists, psychiatrists who believed that psychiatry was of value, but only if it were profoundly changed, found a voice in the journal *Radical Therapist*. The journal, which was founded it 1970, was renamed *Rough Times* in 1972. John A. Talbott, "Radical Psychiatry: An Examination of the Issues," *American Journal of Psychiatry*, Vol, 131 (1974). The most prevalent anti-psychiatrist during the period, however, was undoubtedly Thomas Szasz, a fully trained psychiatrist whose views were regularly published and, subsequently, attacked in mainstream psychiatric

United States was "sick" and in need of psychiatric attention.[57] Moreover, the mental ills believed to be affecting Americans and, especially, young Americans were characterized by behaviours reflected in what is now ADHD.

The most significant of these social factors in creating psychiatric perceptions was the gravitational pull of the baby boom generation throughout the 1950s and 1960s. Psychiatrists were attracted to the cohort's needs, passions, and aggravations partly because it was so prevalent in American society,[58] but also because they saw the vicissitudes of the baby boom as an enormous opportunity for growth in their profession.[59] As the experiences and expectations of children changed, behaviours that were thought to be non-threatening, or even useful, now worried Americans. Psychiatrists took advantage of these concerns and attempted to correct the troubling behaviour of American children and youth. Most of the behaviours identified by psychiatrists as problematic fit into the spectrum of behaviours that characterize ADHD today. Defiant draft dodgers, aggressive race rioters, impulsive drug users, students distracted from their studies and traditional values by the lure of protest, and the hyperactive spirit of the times all played a major role in attracting psychiatrists to what is now identified as ADHD. By the 1960s, psychiatrists had began to pathologize these behaviours, which, in other circumstances, could have been seen as positive.

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journals.

[57] H. Stuart Hughes, "Emotional Disturbance and American Social Change, 1944-1969," *American Journal of Psychiatry*, Vol. 126 (1969/1970), 22.

[58] Charles E. Strickland and Andrew M. Ambrose, "The Baby Boom, Prosperity, and the Changing Worlds of Children, 1945-1963," in Joseph M. Hawes and N. Ray Hiner (eds.) *American Childhood: A Research Guide and Historical Handbook* (Westport, Connecticut: Greenwood Press, 1985), 566.

[59] Walter E. Barton, "Presidential Address: Psychiatry in Transition," *American Journal of Psychiatry*, Vol. 119 (1962/1963), 1.

Correspondingly, during the educational crisis following the Soviet launch of *Sputnik* in 1957, the social optimism of the Kennedy years, and the intense social crises of the mid to late 1960s, both reformers and reactionaries looked to psychiatry for guidance and solutions to America's problems, many of which involved dealing with or learning from the trials and tribulations of the baby boom generation. Under pressure from the anti-psychiatry movement, but also supported by progressive politicians such as President Kennedy and given a certain celebrity status in Hollywood films, American psychiatry was under the spotlight during the 1960s.[60] There existed a certain trust in the profession's ability to be a positive force for change in American society,[61] a trust reflected in President Kennedy's support of psychiatry. This was a significant departure for a profession that was traditionally the least scientifically respected of the medical professions.[62] Encouraged by such support, American psychiatry leaped at the opportunity presented to them by Kennedy and the American public to play a leading role in addressing the social problems being acted out by the baby boom generation, despite the lingering possibility of not meeting society's great expectations.

The Baby Boom: Under the Microscope

In order to understand any aspect of American society of the 1950s and 1960s, one must address how it was affected by the baby boom generation. The nation during these decades revolved around the 75 million or more Americans who were born between 1946

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[60] Psychiatrists were showcased in a positive light in 22 Hollywood films between 1958 and 1963. Gerald N. Grob, *From Asylum to Community*, 273.

[61] Gerald N. Grob, *From Asylum to Community*, 273.

[62] Historians Gerald N. Grob, Charles E. Rosenberg, and Jack D. Pressman have all outlined various aspects of American psychiatry's struggle with scientific legitimacy during the twentieth century. Gerald N. Grob, *Mental Illness and American Society, 1870-1940* (Princeton, New Jersey: Princeton University Press, 1983); Grob, *From Asylum to Community*; Rosenberg, *Explaining Epidemics*, 245-257; Pressman, *Last*

and 1964.[63] From buying a house in the expansive suburbs because it was perceived to be a better place to raise a family to a juvenile products industry worth $33 billion a year to the birth of rock and roll and student protests, American life centred on the economic, cultural, and social interests of American youth.[64]

But the importance of the baby boom generation was due to more than mere numbers. The entrenched competition with the Soviet Union for ideological, intellectual, physical, and technological (as well as military) superiority added a filter of urgency and desperation to how Americans viewed the baby boomers. Historians Steven Mintz and Susan Kellogg argue that American society during this period was "filiarchal," that is, dominated by and greatly concerned with American sons and daughters.[65] Mintz and Kellogg's conception of filiarchy can even be implicated in the American Cold War policy of the 1950s, a policy that, through the rapid expansion of the military industrial complex, provided another enormous stimulus to the economy. The root causes of McCarthyism, strident anti-communist rhetoric, and the reactionary response towards the civil rights movement during the period all involved the baby boom generation, its ideological education, and political beliefs. In this way, the baby boom generation provided the American government with even more compelling reasons to pursue aggressive Cold War policies both at home and abroad. Moreover, it is clear that the

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Resort.

[63] Demographers often argue that a baby "boomlet" started as early as 1942 as couples decided to have children before the men left to fight in the Second World War. Stuart A. Kallen, "Introduction: The Influences of a Generation" in Stuart A. Kallen (ed.) *The Baby Boom* (San Diego: Greenhaven Press, Inc, 2002), 12.

[64] Landon Y. Jones, "A Booming Baby Explosion" in Stuart A. Kallen (ed.) *The Baby Boom* (San Diego: Greenhaven Press, Inc., 2002), 32-35.

[65] Steven Mintz and Susan Kellogg, *Domestic Revolutions: A Social History of the Family Life* (New York: The Free Press, 1988), 184-187.

buoyant economy, fuelled by the consumerism associated with the baby boom, provided a powerful symbol of America's emergence as a world superpower.

With such attention being paid to the baby boom generation, it is not surprising that the American psychiatric profession found itself drawn to the cohort, its problems, and its prospects. Under such intense scrutiny, however, the generation revealed as many flaws as virtues and it was on these shortcomings that psychiatrists focussed. Certainly many psychiatrists, like Franklin G. Ebaugh, a prominent psychiatrist and promoter of the profession, warned that a child-centred culture was psychologically unhealthy for the children growing up in it. Ebaugh, whose views reflected those of other leading psychiatrists such as Joseph D. Noshpitz and Calvin F. Settlage,[66] felt that child-centred parenting and educational practices created "no more than a permanent 'child,' a psychological cripple perennially seeking meanings on the prairies of Beatnikville, instead of fulfilling his future in Communityville."[67] While some of the criticisms of the baby boomers' participation in social unrest during the 1960s involved the perception that the generation itself had forsaken traditional American values,[68] other criticism involved

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[66] Joseph D. Noshpitz, "Toward a National Policy for Children," *Journal of the American Academy of Child Psychiatry*, Vol. 13 (1974), 385; Calvin F. Settlage, "Adolescence and Social Change," *Journal of the American Academy of Child Psychiatry*, Vol. 9 (1970), 210-214.

[67] Franklin G. Ebaugh "Comment: The Case of the Confused Parent," *American Journal of Psychiatry*, Vol. 116 (1959/1960), 1136.

[68] It should be noted that while many young Americans during the 1960s condoned traditional values, supported American involvement in Vietnam (some by enlisting in the armed forces), and joined the work force in much the same manner as their parents, the perception of most Americans, and especially most American psychiatrists, was that this was a generation that rejected traditional American values and ways of life. This perception was reflected in numerous psychiatric articles including those by psychiatrists Joseph D. Noshpitz, Richard E. Troy, and Frank S. Williams. Therefore, when I speak of baby boomers in the 1960s, it will be this perception, however inaccurate, that is represented. Joseph D. Noshpitz, "Certain Cultural and Familial Factors Contributing to Adolescent Alientation," *Journal of the American Academy of Child Psychiatry*, Vol. 9 (1970), 218; Richard E. Troy, "Psychiatry and the Teen-Age Rebellion," *American Journal of Psychiatry*, Vol. 124 (1967-1968), 994; Frank S. Williams, "Alienation of Youth as reflected in the Hippie Movement," *Journal of the American Academy of Child Psychiatry*, Vol. 9. (1970), 263.

societal developments that emerged alongside of and thrived because of the baby boom. Some examples included in this later category are television, rock and roll, suburbanization, and the crisis in the educational system.

Of these features of the baby boom generation, the educational crisis provides the best window into the focus on and concerns with the cohort and, subsequently, insight into why hyperactivity became an important issue. One very significant difference between the baby boom generation and those preceding it was its high level of education. While only twenty percent of young Americans during the late 1930s graduated from high school and sixteen percent went to college, over three times as many baby boomers (who made up a much larger cohort) graduated from high school and half went to college by the 1960s.[69] The educational system attempted to respond to these unprecedented demands, but unfortunately, the sheer numbers, the added expectations, and other factors made this task insurmountable and the system deteriorated.[70] Moreover, it was noted by psychiatrists that the behaviours characterized by ADHD "became less acceptable as the school-based learning system became more concrete and demanding."[71]

One of the problems was that the American educational system had been under a great deal of stress since the Great Depression. Poor economic times followed by a wartime economy left little money to repair or build new schools. Qualified teachers had traditionally been in short supply in many areas of the United States, but during the war and in the years that followed, inflation eroded the real value of teacher salaries, making

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[69] Kallen, "Introduction," *The Baby Boom*, 20.
[70] Irving Bernstein, *Promises Kept: John F. Kennedy's New Frontier* (New York: Oxford University Press, 1991), 219.
[71] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American*

the profession even less attractive, especially to men. Moreover, high marriage and birth rates, the low age of marriage and bearing children, and the renewed expectation, following the end of the Second World War, that married women stay in the home also contributed to fewer women willing to get in front of the classroom.[72] The end result of these problems was that baby boomers went to school in overcrowded classrooms and were often taught by under-qualified teachers.[73] On their own, these conditions would appear sufficient to increase the numbers of children having trouble in school, but other factors led to the perception that the American school system and the children served by it were in trouble.

Specifically, these serious logistical concerns were compounded by pressures on and expectations of the school system that emanated from the Cold War and social changes in the United States. Popular opinion often suggests that the 1950s in the United States was a decade characterized by confidence, calm, and contentment, sentiments buoyed by the thriving economy, a relative thaw in the Cold War, following the end of the Korean War and death of Stalin in 1953, and the rise of the nuclear family. Historian Irving Bernstein has cautioned against this idea, intimating that at best only the four middle years of the decade (1953-1957) can be accurately described as reflecting such a serene atmosphere.[74] The early 1950s, for example, were characterized by McCarthyism, American military difficulties in Korea, and the Soviet Union's emergence as a nuclear power. During 1957 Khrushchev won supreme power in the Kremlin and determined that

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Psychiatric Academy, 528.

[72] Doug Owram, *Born at the Right Time: A History of the Baby-Boom Generation* (Toronto: University of Toronto Press, 1996), 6, 116.

[73] Owram, *Born at the Right Time*, 116.

the Soviet Union would outstrip the Americans militarily and technologically. In that pivotal year he received his wish, as the Soviets put two *Sputnik* satellites into orbit and tested a powerful hydrogen bomb.[75] Meanwhile, on American soil, precursors of the social crises that would take place in the 1960s were occurring. Although rock and roll, the beat generation, and juvenile delinquency all worried Americans, the most vivid example of this was when racial tensions over desegregation erupted into violent conflict during the fall of 1957 in Little Rock, Arkansas, commencing protracted struggles over the issue throughout the South.[76]

All of these developments exerted pressure on the already harried education system, and the baby boomers who were subject to it. While desegregation certainly contributed to educational turmoil in the South, the perception that the United States was failing to keep up with Soviet scientific and technological advances and, thus, was losing the ideological battle in the Cold War, encouraged many politicians and educators to look to the schools for both the causes for and solutions to American shortcomings. Fears of Soviet intellectual superiority, for example, led to the publishing of numerous criticisms of American education and American youth, including popular polemics *Why Johnny Can't Read* (1955) and *Why Ivan Can Read* (1956), but also more academic works such as Arthur E. Bestor Jr.'s *Educational Wastelands* (1953), Hyman G. Rickover's *Education and Freedom* (1959), and Max Rafferty's *Suffer, Little Children* (1962).[77] Rafferty, for example decried the "decline of a once noble breed..." and that the "worst of

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[74] Bernstein, *Promises Kept*, 10.
[75] Bernstein, *Promises Kept*, 9-10.
[76] Diane Ravitch, *The Troubled Crusade: American Education, 1945-1980* (New York: Basic Books, 1983), 136-138.

our youngsters [are] growing up to become booted, side burned, duck tailed, unwashed, leather-jacketed slobs; the best of our youth [are] coming into the world... with everything blurred, with no positive standards, with everything in doubt."[78] The message in such works was very clear: education was to be the battleground on which the Cold War would be won or lost and as of the early 1960s, the perception was that the Soviets were winning.[79]

The outpouring of youth unrest and agitation associated with the civil rights movement, anti-war protests, and drug culture of the 1960s also presented a warning to American politicians, educators, and psychiatrists that the baby boom generation was in trouble. According to some contemporary psychoanalytic psychiatrists, such as Joseph D. Noshpitz, youth unrest, manifested in everything from anti-war protest to gangs in the ghetto, was actually an instance of Freudian transference. Young people were merely acting out the internalized grievances of their parents. Young men with long hair, wearing sandals, and sporting earrings, for example, were thought to be representing their emasculated fathers, raised on cowboys and Indians, but actually working in unmanly offices or classrooms. While such views were not overly widespread, they certainly reflected the lengths to which psychiatrists would go to explain the perceived pathologies of youth.[80] Letters to the editor of *The American Journal of Psychiatry*, such as the one by psychiatrist Richard E. Troy, reflected that mainstream psychiatric opinion was less

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[77] Gutek, *Education in the United States*, 275-279.
[78] Max Rafferty in Louis Jolyon West, "Psychiatry, 'Brainwashing,' and the American Character," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 842.
[79] Trace, Jr., *What Ivan Knows That Johnny Doesn't*, 3.
[80] Noshpitz, "Certain Cultural and Familial Factors," *Journal of the American Academy of Child Psychiatry*, 216-218.

complicated. Troy contended that the lack of consistent limits set up for youth behaviour led to the severe social upheavals of the 1960s and if previous behaviour standards were not reinforced, such unrest was bound to continue.[81]

The perception that American youth was in decline led many American politicians and educators to search for a culprit responsible for the alarming new values of American youth and their failure to keep up with their Soviet counterparts. Their accusations of blame quickly targeted the prevailing educational and parenting philosophies of the day, namely the progressive education movement and permissive child-rearing, as well as their chief spokesmen, John Dewey and Benjamin Spock respectively. Both philosophies, especially when pursued haphazardly, were perceived to create environments in which the symptoms of hyperactivity were ignored, tolerated, or accepted.

Progressive education emerged out of the 1920s and 1930s as a rejection of the prevailing authoritarian, subject-centred, and rigid model and in favour of one that was democratic, experimental, egalitarian, and above all, child-centred.[82] By the 1940s progressive education was "the dominant American pedagogy,....the conventional wisdom, the lingua franca of American educators."[83] Although progressive education had its roots in the theories of many American social reformers, including Jane Addams and Jacob Riis, it is most commonly associated with the educational philosophy of John Dewey.[84] Dewey believed that in order for American children to learn how best to adapt to their increasingly industrial and urban country, they had to be taught the value of order,

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[81] Troy, "Psychiatry and the Teen-Age Rebellion," *American Journal of Psychiatry*, 994.
[82] Ravitch, *The Troubled Crusade*, 44.
[83] Ravitch, *The Troubled Crusade*, 43.
[84] Ravitch, *The Troubled Crusade*, 46.

industry, responsibility, and good social habits, in other words, be trained "in relation to the physical realities of life."[85] The Deweyan teacher had to be extremely well educated and perceptive in order to set up situations in which the students would learn or discover elements of science, mathematics, or the arts through experience and be directed to higher levels of social and cultural understanding.[86] The difficulties inherent in finding teachers able to realize Dewey's high expectations, combined with his esoteric writing style, meant that Deweyan educational theories were often misconstrued.[87] The resulting classrooms tended not to be orderly and scientific, but chaotic and aimless, where hyperactivity, distractibility, impulsivity, defiance, and aggression would go unchecked.[88] It followed that Dewey's name, despite his best intentions, became associated with child-centred and un-intellectual schooling and he became the primary target of the critics of progressive education.

The other name that was targeted by Americans concerned with the state of the nation's youth was that of Benjamin Spock. Dr. Spock's *The Common Sense Book of Baby and Child Care* published in 1946, the year the first baby boomers were born, became the best selling book in the twentieth century (next to the Bible), selling twenty-eight million copies during its first thirty years of publication.[89] Spock's advice to parents was to raise their children in a relatively permissive manner, in marked contrast to the strict behaviourism that characterized the child-rearing of the previous generation, and to trust in their parental instincts. Spock, like Dewey, was often misunderstood by both

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[85] Joel Spring, *The American School 1642-1993* (Third Edition, New York: McGraw-Hill, Inc., 2002).
[86] Ravitch, *The Troubled Crusade*, 47
[87] Spring, *The American School*, 203.
[88] Spring, *The American School*, 203.

his critics and adherents. To follow Spock's advice accurately, a parent, usually a mother, would have to spend an inordinate amount of time and thought on child-rearing, an expectation that was reminiscent of Dewey's high expectations of teachers. Since many mothers lacked the time and energy required, Spockian strategies were often rejected for rigid, behaviourist, traditional methods or mutated into a "child-centred anarchy" in which parents ignored their children, allowing them to behave as they wished.[90] As such, parents were likely to tolerate their child's impulsive, distractible, hyperactive, and defiant behaviour.

Critics of Spock in the 1950s believed that this latter effect of his advice, the unbridled permissiveness and "filiarchal" state of family affairs, would put into jeopardy the creation of a generation of disciplined and industrious workers and professionals necessary to compete with the Soviets "in the child-raising race."[91] Looking back on the 1960s, the president of the American Psychiatric Association in 1970, Raymond W. Waggoner, Sr., blamed permissiveness for the "dissonance of youth during the period."[92] Indeed, Spock, concerned with what he called "overpermissiveness" in American childrearing during the late 1950s and 1960s, tried to clarify his views by founding a Cold War parent education project, Parenthood in a Free Nation, that stressed the importance of putting appropriate limits on child behaviour.[93] Following the Soviet launch of *Sputnik I*, however, even Spock's clarified theories were thought to be a woefully

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[89] Strickland and Ambrose, "The Baby Boom" in *American Childhood*, 539.
[90] Strickland and Ambrose, "The Baby Boom" in *American Childhood*, 539.
[91] Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (Garden City, New York: Anchor Books, 1979), 255-257.
[92] Raymond W. Waggoner Sr., "The Presidential Address: Cultural Dissonance and Psychiatry," *American Journal of Psychiatry*, Vol. 127 (1970/1971), 8.
[93] Ehrenreich and English, *For Her Own Good*, 255.

inadequate response to a Soviet system that created not only disciplined, but creative citizens.[94]

One of the leading critics of progressive educational and parenting practices was James Bryant Conant, whose notable accomplishments included being president of Harvard University, ambassador to West Germany, and the first chairman of the board of the National Science Foundation. Conant began a series of investigations of American schools in 1957 and among other things, concluded that students did not work hard enough and that too much time was wasted on extracurricular activities such as sports and music.[95] Conant's criticisms, which lacked the polemical style and acrimony of other critics like Rickover, Bestor, and Rafferty, had a profound impact on education policy.[96] Published in *The American High School Today,* which became a surprise best-seller, Conant's views were widely accepted in conservative circles and school officials hastened to put his recommendations into practice.[97] By 1958, Conant's efforts had compelled Congress to pass the National Defence Education Act that provided financial aid to encourage the study of science, mathematics, and foreign languages, as well as funding for school construction and equipment.

Although Conant's nationalistic motives were clear, he also stressed that the success of all students, not simply the best and brightest, was of great importance.[98] Conant rejected a return to the traditional preparatory approach to schools that had

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[94] Ehrenreich and English, *For Her Own Good*, 257.
[95] Willis Rudy, *Schools in an Age of Mass Culture: An Exploration of Selected Themes in the History of Twentieth Century American Education* Englewood Cliffs, New Jersey: Prentice Hall, 1965, 319- 320.
[96] Gutek, *Education in the United States*, 281.
[97] Ravitch, *The Troubled Crusade*, 230.
[98] It could be argued that Conant's inclusive educational philosophy contributed to American legislation such as the Individuals with Disabilities Education Act (1975) which integrated students with disabilities

screened out poor students as they reached higher grades. By supporting a school system modelled on an egalitarian meritocracy, in which the academically gifted from all socio-economic backgrounds were recognized by guidance counsellors and given financial support, while the academically challenged were placed in vocational programs, Conant at once increased the demands placed on all students in an attempt to utilize the latent academic talent that he felt was currently floundering in the schools. As the scholastic expectations of all baby boomers increased, so too did the efforts of educators and psychiatrists to identify and treat the learning problems that interfered with the realization of the generation's academic potential.

The anxiety of Conant and others about the baby boom's academic abilities retreated from the public spotlight during the 1960s,[99] but it was replaced with even more troubling concerns about the mental health of young Americans. Views like those of psychiatrist Eleanor Pavenstedt, that American domestic problems, especially racism, poverty, urban decay, and "[the] subcultures who congregate in certain areas of our cities," were all harming the mental health of young people, reinforced the idea that American youth were at risk.[100] These concerns emerged primarily out of American military experience. Following the conclusion of the Second World War, statistics from the American draft board war records showed that over two million men were rejected for or discharged from military service for psychiatric problems, the most common reason.[101] A few years later, reports from the experiences of the nearly seven thousand American

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into regular classrooms in the attempt to help them reach their academic and social potential.

[99] Ravitch, *Troubled Crusade*, 229.

[100] Eleanor Pavenstedt, "Introduction to the Symposium on Research on Infancy and Early Childhood," *Journal of the American Academy of Child Psychiatry*, Vol. 1 (1962), 7-8.

prisoners of war in North Korean and Chinese camps during the Korean War indicated that most American prisoners were severely demoralized, one-seventh had succumbed to communist brainwashing (a phenomenon portrayed in the 1962 film *The Manchurian Candidate*, starring Frank Sinatra), and others had simply perished due to what psychiatrists bluntly termed "give-up-itis."[102] It should be noted that some psychiatrists downplayed the fears of American susceptibility to brainwashing. Louis Jolyon West, for example, criticized the "great brainwashing hoax" and fears for American character, stating that the willingness of thousands of young Americans to participate and risk their lives in the Peace Corps proved that young Americans were still brave and patriotic, but perhaps in a more sensitive way.[103]

Nevertheless, the prevailing opinion amongst psychiatrists was that the mental health of American youth was in a precarious state. There were growing fears amongst contemporary psychiatrists such as Stuart M. Finch[104] about juvenile delinquency and youth gang violence, not only in the urban ghettos, but also in the suburbs.[105] By the early 1960s an alarming half a million American youngsters were described by the courts as juvenile delinquents, involved in what Finch termed criminal (for-profit crime), conflict (violence and vandalism), or retreatist (drug abuse) subcultures and the numbers were expected to reach into the millions as the baby boomers entered their teens.[106]

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[101] Ehrenreich and English, *For Her Own Good*, 235.
[102] Ehrenreich and English, *For Her Own Good*, 253.
[103] Louis Jolyon West, "Psychiatry, 'Brainwashing,' and the American Character," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 842-848.
[104] Stuart M. Finch, "The Psychiatrist and Juvenile Delinquency," *Journal of the American Academy of Child Psychiatry*, Vol. 1 (1962).
[105] Ehrenreich and English, *For Her Own Good*, 253.
[106] Finch "Psychiatrist and Juvenile Delinquency," *Journal of the American Academy of Child Psychiatry*, 619, 626.

Although permissive or overpermissive mothers were blamed by psychiatrists for juvenile delinquency in the 1950s,[107] during the early 1940s, rising levels of juvenile delinquency were also attributed to mothers who worked as part of the war effort.[108] Women were blamed in each instance, but for contradictory reasons. The perceived absence of maternal influence was thought to be the cause during wartime, but by the 1950s, excessive maternal devotion was the reason. Mothers, therefore, were presented with very mixed messages about proper parenting techniques. This is likely one reason that Spock's advice to trust one's instincts was so popular. With regards to hyperactivity, in particular, only psychoanalysts tended to blame mothers for the hyperactivity in their children.[109] Psychoanalysts also attributed breakdowns in the father-child relationship for hyperactivity and rarely implied that either parent could have prevented such behaviour without the aid of a trained psychoanalyst. Whatever the cause, it was clear that psychiatrists believed the youth of America to be lagging intellectually, especially when compared to Soviet children, but also to be psychologically damaged, morally soft, and deviant. What had led to this precarious state of affairs? Why were matters thought to be so dire? Most importantly, what was to be done to make matters right?

The answers to these questions contribute to why hyperactivity became such a popular field of study for American psychiatrists during the 1960s. First, the combination

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[107] Ehrenreich and English, *For Her Own Good*, 254.

[108] Ronald D. Cohen, "Schooling Uncle Sam's Children: Education in the USA, 1941-1945," in Roy Lowe (ed.) *Education and the Second World War: Studies in Schooling and Social Change* (London: The Falmer Press, 1992), 52.

[109] For example, James F. Masterson, Jr., Kenneth Tucker, and Gloria Berk, "Psychopathology in Adolescence, IV: Clinical and Dynamic Characteristics *American Journal of Psychiatry*, Vol. 120 (1963/1964), 364; Rachel M. Rosenberg and Barbara C. Mueller "Preschool Antisocial Children: Psychodynamic Considerations and Implications for Treatment," *Journal of the American Academy of Child Psychiatry*, Vol. 7 (1968), 428.

of Cold War jousting over intellectual superiority and the massive numbers of American children who represented the pawns in such a competition meant that the educational experience of the baby boom generation was subjected to intense scrutiny. Adding to these concerns, however, was the prediction by demographers, sociologists and many psychiatrists that increased automation of the workplace would necessitate a workforce with much more advanced employment skills; dropping out of school and immediately obtaining employment as an unskilled labourer would soon become an anachronism. Educational psychologist Ralph W. Tyler, for example, warned that while automation would create new employment opportunities, for example, building and maintaining automated systems, much higher standards of education and a greater social awareness of the importance of education would be needed in order to meet the demands of an automated workplace.[110] Psychiatrists trumpeted their own concern about the unsuitability of the typical American youth for what was thought to be a changing workplace and offered their assistance to alleviate the situation. Commenting on President Kennedy's proposed mental retardation program during the 120th annual meeting of the American Psychiatric Association, for example, psychiatrist Stafford L. Warren suggested that the United States could "no longer ignore the early school dropout on the excuse that we need a large labour force of uneducated muscle men." Warren went on say that even the five million mentally retarded individuals in the United States (who would today be referred to as developmentally delayed) must be transformed into tax payers. In order for this to occur, they would have to be trained to do more

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[110] Ralph W. Tyler, "New Trends in Education," *American Journal of Psychiatry*, Vol. 122 (1965/1966), 1394-1395.

sophisticated types of work and avoid jobs that were thought to be soon replaced by automation in factories.[111]

Some psychiatrists were concerned about the vicissitudes of automation itself, including the anticipated shorter work weeks and increase in leisure time. Notable psychiatrists such as Huston Smith ranked increased leisure time as the number one concern for psychiatrists in the next decade and former American Psychiatric Academy President Henry W. Brosin worried about America's ability to "survive the affluence of a truly cybernated society,....creating problems never before encountered in the areas of free time or leisure, occupational obsolescence and displacement." The most concerned psychiatrist, however, was Werner M. Mendel who went so far as to say that if American children were not properly educated on how to spend such hours meaningfully, the United States would be subject to epidemic levels of depression.[112] Fortunately (or not), baby boomers were never faced with the calamitous results of the feared twenty-hour work week. Whether or not psychiatrists believed that technological progress in the workplace was a boon or a curse, they were in agreement that a very high percentage of the baby boom generation would have to finish high school and go on to college or university in order to meet the needs of the new workplace and make up the perceived intellectual gap with the Soviets.

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[111] Stafford L. Warren, "Implementation of the President's Program on Mental Retardation," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 550-551.

[112] Howard P. Rome, Nevitt Sanford, Huston Smith, Noah Weinstein, and Leonor K. Sullivan, "Psychiatry Viewed from the Outside: The Challenge of the Next Ten Years," *American Journal of Psychiatry*, Vol. 123 (1966/1967), 522-523; Henry W. Brosin, "The Presidential Address: Adaptation to the Unknown," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 4; Werner M. Mendel, "Leisure: A Problem for Preventative Psychiatry," *American Journal of Psychiatry*, Vol. 127 (1970/1971), 1688-1691.

Since the expectations of school achievement for the baby boom generation were so high, the problems of children who had educational and social difficulties were increasingly recognized, identified, and studied. A crucial debate in psychiatric theory, however, amplified the importance of such studies to an enormous degree. By the 1960s, psychiatrists were beginning to question previous notions put forth by theorists like psychoanalyst Eric Erikson that many of the pathologies of adolescence were merely developmental or transitional in nature. In other words, psychiatrists, especially those who favoured biological or behavioural approaches (for example, James F. Masterson, Sigmund Gundle, and others), ceased to assume that children and adolescents would simply outgrow their disorders.[113] Instead, many psychiatrists began to assume that a relatively minor disorder like hyperactivity might persist into adulthood where it would hinder the individual's employability and work performance and perhaps lead to more serious conditions like depression or even schizophrenia.[114] According to Masterson, Erikson's "dangerous [ideas] prevented a therapeutic intervention,"an intervention that could be "a crucial encounter for the adolescent."[115] This shift in developmental theory reinforced the need for "therapeutic intervention," but also signified a need for greater numbers of child psychiatrists.

This new concern represented a major shift in American psychiatry from the pre-war period and was reflective of general changes to the profession during the postwar

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[113] Masterson, Jr., Tucker, and Berk, "Psychopathology in Adolescence," *American Journal of Psychiatry*, 363; Sigmund Gundle, "Discussion," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 365; James F. Masterson, Jr., "The Symptomatic Adolescent Five Years Later: He Didn't Grow Out of It," *American Journal of Psychiatry*, Vol. 123, (1966/1967), 1338, 1345.

[114] Leighton Y. Huey, Mark Zetin, David S. Janowsky, and Lewis L. Judd "Adult Minimal Brain Dysfunction and Schizophrenia: A Case Report," *American Journal of Psychiatry*, Vol. 134 (1977), 1563.

[115] Masterson, "Symptomatic Adolescent," *American Journal of Psychiatry*, 1338, 1344.

period, most importantly deinstitutionalization. Deinstitutionalization reduced the numbers of patients in psychiatric hospitals from over five hundred thousand to three hundred thousand by the early seventies, a trend that continued into the 1980s.[116] As American psychiatry re-oriented itself away from large psychiatric hospitals, the profession's focus shifted to less severe mental ailments and patients who could live in the community.[117] This transition was due in part to attacks on the hospitals from critics ranging from Irving Goffman to President Kennedy, as well as the immense costs these state hospitals incurred, but also because of the increasing dominance of psychoanalysts during the postwar period who tended to work in private practice, treating less serious conditions.[118] It also reflected the profession's decades old ambition to transcend the state psychiatric hospital and become more involved in the mental health of "normal" Americans, an ambition that was envisioned by Adolph Meyer in the 1920s.[119]

Similarly, most research on child psychiatry in *The American Journal of Psychiatry* before the 1950s was directed at childhood psychiatric ailments that would have been deemed serious enough to warrant institutionalization, such as schizophrenia, autism, and Tourette's syndrome.[120] The hyperactive behaviour that was identified by pre-war psychiatrists as being problematic, for example, was severe enough for the

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[116] Gerald N. Grob, *From Asylum to Community*, 291.
[117] Gerald N. Grob, *From Asylum to Community*, 302-304.
[118] Goffman, *Asylums*; John F. Kennedy, "Message from the President of the United States Relative to Mental Illness and Mental Retardation," *American Journal of Psychiatry*, Vol. 120 (1963/1964); Nathan G. Hale, Jr., "American Psychoanalysis Since World War II," in Roy W. Menninger and John C. Nemiah (eds.) *American Psychiatry after World War II* (Washington, D.C.: American Psychiatric Press, Inc., 2000), 80-95.
[119] Pressman, *Last Resort*, 32-38.
[120] It is ironic that while thousands of severely disturbed children were released from institutions during the deinstitutionalization of the 1960s, millions more children were concurrently diagnosed and treated with less severe problems like hyperactivity.

handful of diagnosed children to be institutionalized and indeed, most research on hyperactivity before the 1960s was done on children in psychiatric institutions. By the 1960s, however, it was seen as quite a common problem for children going to school. This emphasis on more benign mental disorders combined with the overarching concern with children's mental health meant that conditions like hyperactivity were increasingly investigated by psychiatrists. Moreover, the fear that children did not simply grow out of childhood disorders, reflected in the move away from Erikson's developmental conceptions about childhood mental health, led psychiatrists to be more concerned about the prognosis of hyperactivity. Therefore, as more students stayed in school for longer periods of time (that is, not dropping out to find work), more were diagnosed with hyperactivity.

Other factors reinforced the tendency to focus on less serious childhood psychiatric disorders and syndromes during the 1960s. For instance, more guidance counsellors were hired by schools to identify minor childhood psychiatric pathologies. Psychiatrists viewed this as a mixed blessing. While psychiatrist Henry A. Davidson recognized that psychiatrists were defensive about sharing their authority with allied health professionals, guidance counsellors did refer patients to psychiatrists for treatment.[121] Certainly many psychiatrists looked to develop better relationships with schools in order to provide more effective treatment for children, but also to extend their authority into the classroom.[122] Historian S. Alexander Rippa has noted that following

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[121] Henry A. Davidson, "Correspondence: Psychiatrists," *American Journal of Psychiatry*, Vol. 119 (1962/1963), 795.

[122] Eveoleen N. Rexford, "Child Psychiatry and Child Analysis in the United States," *Journal of the American Academy of Child Psychiatry*, Vol. 1 (1962), 376; Stonewall B. Stickney, "Schools Are Our

the Second World War there was a growing trend for schools to hire guidance counsellors who then identified and brought attention to youth who diverged from the norm in terms of behaviour or school performance.[123] The vast majority of students who would have left school in their early teens to join the workforce before or during the Second World War were, by the 1950s, encouraged to stay in school where a guidance counsellor could identify them with learning problems like hyperactivity.

Depending on the vocation these young people chose, it is quite possible that their hyperactive symptoms went unnoticed or even assisted them in their jobs. This is due to the fact that many common vocations before the Second World War were suitable for those with hyperactive tendencies. In order to explain why this is the case, it is helpful to explore the role of stimuli with regards to hyperactivity. Although psychiatrists during the 1960s and 1970s commonly treated children with stimulant drugs like methlyphenidate (Ritalin), they had difficulty explaining why such treatment helped hyperactive children.[124] It seemed counter-intuitive that a distractible child needed more stimuli in order to concentrate. Today, psychiatrists attempt to explain this paradox by suggesting that the symptoms of ADHD are triggered by brain hypoactivity, or lack of stimulus. Therefore, the individual with ADHD exhibits hyperactivity in an effort to self-stimulate when his environment is not providing enough stimuli. As such, many individuals with hyperactivity traditionally chose and continue to choose occupations in which they are presented with a great deal of either physical or visual stimuli (for

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Community Mental Health Centers," *American Journal of Psychiatry*, Vol. 124 (1967-1968), 1407.

[123] S. Alexander Rippa, *Education in a Free Society: An American Tradition* (Eighth Edition; White Plains, New York: Longman, 1997), 262-263.

[124] Larry B. Silver, "The Playroom Diagnostic Evaluation of Children with Neurologically Based Learning

example, truck driving, skilled and unskilled labour, and even working as a policeman or emergency services worker).

Three factors made vocations like these less possible following the Second World War, however. First, the desirability of most manual or skilled labour occupations decreased when soldiers returning from the Pacific, Europe, and later, Korea, were provided with funding to go to college through the GI Bill (1944).[125] Educated veterans, often the first in their family to receive a college education, often eschewed the idea of labour intensive work for their children. They subsequently expected their children, the baby boom generation, to similarly complete high school and go to college. Therefore, these youth were kept in the education system during the 1950s and 1960s where their learning problems were identified and diagnosed. Concurrently, the idea that automation would revolutionize the workplace implied that there would be fewer jobs available for skilled and unskilled labourers. Finally, occupations that carried more prestige, paid more, and were suitable for those diagnosed with ADHD, such as policing, nursing, or fire-fighting, increasingly required new recruits to have at least a high school diploma and later, a post-secondary diploma or a degree, educational qualifications that were difficult for the hyperactive individuals to attain. With new demands and qualifications expected from the baby boom generation, it should not be surprising that many young people were unable to make the grade.

Although all of the above factors, the focus on the baby boom and its education, mental health, and vocational prospects, encouraged American psychiatrists to turn their

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Disabilities," *Journal of the American Academy of Child Psychiatry*, Vol. 15 (1976), 253.
[125] Bernstein, *Promises Kept*, 218.

attention to children and hyperactivity, a final development was needed to entrench their interest in such problems. The final factor that at once crystallized the importance of learning problems like hyperactivity and transferred the responsibility for solutions to such problems from educators to psychiatrists was the impact of the Kennedy administration. Kennedy's keen interest in the mental health of children, willingness to financially support mental health initiatives, and faith in the psychiatric profession gave American psychiatry the added boost it needed to invest its energies towards solving the problem of hyperactivity.

Kennedy's Legacy, Psychiatry, and Hyperactivity

Although the Cold War continued to simmer during the middle of the 1960s, domestic crises supplanted it as the primary source of American fears and anxiety. The values that defined American society were being questioned and often rejected by the cohort that had been doted upon during the 1950s, the baby boom generation. To use the prevailing psychiatric metaphor, American society was thought to be sick and in danger of a breakdown.[126] Many psychiatrists, including David Blain, president of the American Psychiatric Association in 1965/1966, believed that the mental health of children and adolescents was the most pressing concern for psychiatry.[127] According to some psychoanalysts, it was not surprising that adolescents were impulsive, hyperactive, distractible, and defiant, since they were just transferring the characteristics of a society without norms and in dire need of a stronger universal superego.[128] As such, American

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[126] Hughes, "Emotional Disturbance," *American Journal of Psychiatry*, 22.
[127] Daniel Blain "The Presidential Address: Novalescence," *American Journal of Psychiatry*, Vol. 122 (1965/1966), 3.
[128] Calvin F. Settlage, "An Editorial Postscript," *Journal of the American Academy of Child Psychiatry*,

psychiatry during the 1960s and 1970s turned a great deal of its attention to the mental health of children and child psychiatry became an increasingly important field within the profession.[129]

Moreover, psychiatrists were concerned that increased interest in the mental health needs of children was not leading to better results. The explosion in the diagnoses of learning disorders, and especially hyperactivity, was one of the more glaring indicators of this trend.[130] Indeed, Minimal Brain Dysfunction, a term used to describe the symptoms of ADHD, was used by psychiatrists and psychologists as a catch-all to describe many types of learning problems.[131] Some psychiatrists, like James M. Cunningham, believed that a disturbing paradox existed: although society had accepted some responsibility for the welfare of children and committed to some major social changes on behalf of children during the last half century, such as compulsory education, child labour laws, and a juvenile court system, the numbers of mentally troubled children and adolescents continued to increase.[132] While Cunningham's paradox may be explained by acknowledging that increased awareness of pathologies often led to more

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Vol. 9, (1970), 278-281.

[129] David L. Bazelon, "'The Problem Child' - Whose Problem?" *Journal of the American Academy of Child Psychiatry*, Vol. 13 (1974), 194.

[130] Charles Hersch, "Child Guidance Services for the Poor," *Journal of the American Academy of Child Psychiatrists*, Vol. 7, (1968), 224; Henri Parens and Alexander A. Weech, Jr., "Accelerated Learning Responses in Young Patients with School Problems," *Journal of the American Academy of Child Psychiatry*, Vol. 5 (1966), 75.

[131] Donald S. Leventhal, "The Significance of Ego Psychology for the Concept of Minimal Brain Dysfunction in Children," *Journal of the American Academy of Child Psychiatry*, Vol. 7 (1968), 242.

[132] James M. Cunningham, "The American Academy of Child Psychiatry – Prospect" *Journal of the American Academy of Child Psychiatry*, Vol. 3 (1964), 9. C. H. Hardin Branch, president of the American Psychiatric Academy in 1963/1964 recognized the same trend in psychiatry as a whole and blamed it on psychoanalysts focusing their efforts on treating the small percentage of patients able to afford psychotherapy. In other words, there was a discrepancy between the needs of society and the interests of psychiatrists. C. H. Hardin Branch, "Presidential Address: Preparedness for Progress," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 3.

diagnoses, it seemed apparent to the psychiatric community that a renewed investment in and dedication to the prevention and treatment of children's mental illness was needed in order for significant change to occur. Moreover, according to Walter E. Barton, 1962/1963 president of the American Psychiatric Association, if the American government could afford foreign aid, farm surplus programs and a trip to the moon, it could certainly afford adequate funding of mental health care.[133]

The source of such a reinvestment and rededication was to come from John Fitzgerald Kennedy, a president whose brief presidency and senseless assassination provided the psychiatric community with a national mission to eliminate mental illness. President Kennedy's commitment to assisting those afflicted by mental illness and mental retardation was at once a reflection of his own personal interest in the subject and the growing concerns of the nation. Although it was true that his sister's struggles with mental illness (including an eventual lobotomy and confinement in a mental institution) fuelled his passion for the subject, it is also clear that he believed that Americans were genuinely concerned about mental health, and especially that of children and youth, the burgeoning baby boomers. Psychiatrists, for their part, did a great deal to reinforce these concerns. Commenting on the findings of the Joint Commission for Mental Health (1961) for his annual message in the *American Journal of Psychiatry*, Jack R. Ewalt, the 1963/1964 president of the American Psychiatric Association, stressed that the mental health of children was a source of great worry to Americans.[134] Likewise, Ewalt had stressed a few years before that the size of a mental health programme in the United

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[133] Barton, "Presidential Address," *American Journal of Psychiatry*, 3.
[134] Jack R. Ewalt, "Presidential Address," *American Journal of Psychiatry*, Vol.121 (1963/1964), 7.

States needed to match the extent of the problem.[135] Upon the formation of the Joint Commission on the Mental Health of Children (1969), which was intended to address these concerns, child psychiatrist Reginald Lourie reiterated Ewalt's observations, indicating that there was a "groundswell of pressure for a study of the mental health needs of children."[136]

Despite the understandable amount of interest in child and youth mental health during the 1960s, however, it was President Kennedy's personal convictions and, more importantly, assassination and legacy, which provided the political will and financial support necessary for a national program of mental health research and infrastructure development. Following President Kennedy's assassination by Lee Harvey Oswald, Congress passed the Community Mental Health Centers Construction Act that helped to realize some of Kennedy's ambitions for treating the mentally ill.[137] The assassination of the president by someone thought to be insane (someone who might have been helped by improved mental health services) provided Congress with additional motivation to pass the bill, suitably nicknamed the Oswald Bill.[138]

Kennedy's mental health agenda was most clearly articulated in a message he delivered to Congress on February 5, 1963, entitled, "A Message from the President of the United States Relative to Mental Illness and Mental Retardation." In his message, the president made some critical assumptions about the importance of mental health issues,

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[135] Jack R. Ewalt, "The Future of Psychiatry: The Report on the Joint Commission on Mental Illness and Health," *American Journal of Psychiatry*, Vol. 116, (1959/1960), 980.
[136] Reginald Lourie, "The Joint Commission on the Mental Health of Children," *American Journal of Psychiatry*, Vol. 122 (1965/1966), 1280.
[137] Bernstein, *Promises Kept*, 243.
[138] Noshpitz, "Toward a National Policy," *Journal of the American Academy of Child Psychiatry*, 387.

how they should be treated, and the ability of psychiatrists to be successful in their mission.[139] First, the president made it very clear that he thought that America's most urgent and important health care need was to provide better care for those afflicted with mental illness and mental retardation.[140] According to the president, mental illness occurred very frequently, affecting hundreds of thousands of Americans and their families, and was often impossible to cure, resulting in interminable treatment in an "antiquated, vastly crowded chain of custodial state institutions, causing more suffering to family, and a severe drain on their and the government's resources [2.4 billion dollars per year]."[141] The President also believed that despite these investments, psychiatric treatment of mental illness had made very few advances in this or previous centuries. The urgency of the matter, according to the President, however, meant that the nation could not "afford to postpone any longer a reversal in [its] approach to mental affliction."[142] While improving facilities, building community mental health centres, and investing in psychiatric therapies were key pieces of the solution, prevention of mental illness and mental retardation, by "seeking out the causes of mental illness and eradicating them," was the most important.[143] Therefore, emphasis on the healthy mental development of children and adolescents became an essential aspect of Kennedy's plan.

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[139] Kennedy, "Message from the President," *American Journal of Psychiatry*, 729.
[140] Kennedy, "Message from the President," *American Journal of Psychiatry*, 729.
[141] Kennedy, "Message from the President," *American Journal of Psychiatry*, 729. Kennedy's cost estimate was actually low when compared to others. The research of Conley, Conwell, and Arrill in 1967/1968 suggest a figure of twenty billion per year, ten times Kennedy's estimate. Ronald W. Conley, Margaret Conwell, and Mildred B. Arrill "An Approach to Measuring the Cost of Mental Illness," *American Journal of Psychiatry*, Vol. 124 (1967/1968), 755.
[142] Kennedy, "Message from the President," *American Journal of Psychiatry*, 730.
[143] Kennedy, "Message from the President," *American Journal of Psychiatry,* 730, 734.

Second, Kennedy's remedies were not targeted at one particular psychiatric field. By the 1960s, the three psychiatric fields competing for supremacy within the profession were social psychiatry, psychoanalysis, and biological psychiatry. Each field desired to eclipse the other in order to become the authoritative voice in American psychiatry. Kennedy's proposals, however, did not completely favour one field over another. Although Kennedy cited the importance of rapid psychiatric drug development and, therefore, had significant respect for biological psychiatry, he also recognized that mental illness and mental retardation afflicted poorer communities disproportionately and acknowledged the individual's environment as being the most crucial factor in determining the state of their mental health.[144] Contemporary research on housing conditions and children's mental health, for example, showed that children growing up in overcrowded conditions were much more likely to have behaviour problems.[145] This stress on the environmental factors of mental illness, and especially the socioeconomic conditions faced by children, therefore demonstrated a great deal of sympathy with social psychiatry, a newly emerging psychiatric field that blamed poverty and associated social ills for mental illness.

Although Kennedy's primary focus was on the prevention of mental illness by reducing poverty and replacing the "social quarantine" of inefficient, ineffective, and isolated state mental institutions with community mental health centres and a focus on child psychiatry, he did implicitly recruit the services of psychotherapists as the primary

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[144] Kennedy, "Message from the President," *American Journal of Psychiatry*, 732, 734.
[145] E.A. Grootenboer, "The Relation of Housing to Behavior Disorder," *American Journal of Psychiatry*, Vol. 119 (1962/1963), 471.

curative or therapeutic elements in his mental health scheme.[146] While social psychiatrists specialized in preventing mental illness and mental retardation by identifying and eliminating its environmental causes, the pharmacotherapy provided by biological psychiatrists allowed more institutionalized mental patients to be re-integrated into the community where psychoanalysts would treat them in community health centres. In other words, the president's message provided a role for each of the major psychiatric fields.

Understandably, it was with a great deal of optimism and confidence that Kennedy faced up to the monumental challenges he saw posed by mental illness and mental retardation. It seems clear from the determined tone of his message, the amount of money put forth to address the problem (especially in terms of investing in psychiatric research and training – 66 million dollars alone), and the embracing of his plan by Congress following his death, that the president and his supporters truly believed that if enough resources were allocated, psychiatry would be able to solve the venerable riddle of mental illness and set the United States on a clearer path.[147]

For the historian of medicine, perhaps the most striking representation of this confidence is the analogy Kennedy drew between the current challenge presented by mental illness and mental retardation and the medical achievements of the last few decades in fighting many somatic diseases, especially those of an infectious nature. Despite Kennedy's understanding that the treatment of mental illness had not progressed significantly during modern history, he suggested that psychiatrists should be able to

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[146] Kennedy, "Message from the President," *American Journal of Psychiatry*, 731.
[147] Kennedy, "Message from the President," *American Journal of Psychiatry*, 733.

enjoy similar successes as those achieved by physicians who unravelled the mysteries of diseases like polio, diabetes, and yellow fever.[148] Just as Jonas Salk, Frederick Banting, and Walter Reed were able to revolutionize the treatment and/or prevention of these illnesses, so too would psychiatrists triumph over mental illness. According to Kennedy, moreover, the crusade to cure mental illness was no less important. This unbridled optimism transferred quickly to the psychiatric community, giving the profession a unique opportunity to solidify it claim to legitimate medical status. Many leaders in the psychiatric community, such as 1968/1969 president of the American Psychiatric Association, Henry W. Brosin, agreed with the President's assessment of the situation's gravity and psychiatry's ability to address it successfully.[149] Since Kennedy's plan stressed preventative strategies, child psychiatry and the factors affecting the psychological development of children were of crucial importance. It was in this rarefied environment that the diagnosis and treatment of hyperactivity became crucially important to the American psychiatric profession.

The emergence of hyperactivity as a subject of enormous importance to American psychiatry was tied inexorably to the experiences of the baby boom generation growing up in the 1950s and 1960s. The baby boomers not only grew up differently than previous generations, exposed to the pressures of unrealistically high educational expectations, their successes and failures were understood within a context shaped by America's ideological struggle against the Soviet Union. Under these circumstances, behavioural characteristics like hyperactivity, impulsivity, distractibility, defiance, and aggression, not

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[148] Kennedy, "Message from the President," *American Journal of Psychiatry*, 729.
[149] Brosin "Presidential Address," *American Journal of Psychiatry*, 13.

particularly problematic for previous generations, were pathologized, as the benchmarks for academic and occupational success were raised to unprecedented levels. When Cold War fears were replaced by equally pressing concerns about domestic social unrest during the 1960s, these same characteristics appeared to reflect the rebellious behaviours, attitudes, and beliefs of the now adolescent and young adult baby boomers. As a result, such behaviours were pathologized even further. Despite these factors, however, it was President Kennedy's desire to eradicate mental illness and mental retardation, as well as his faith in preventative strategies, which provided the catalyst necessary to spur the American psychiatric community into action. Child psychiatry and especially hyperactivity quickly became popular research topics for American psychiatrists who were determined to realize President Kennedy's mental health legacy. The manner in which the various psychiatric fields addressed the challenge of hyperactivity during the late 1960s and 1970s determined how the disorder would come to be understood both by the medical community and the American public.

The Response of Social, Psychoanalytic, and Biological Psychiatry to Hyperactivity

Although the various psychiatric fields reacted to President Kennedy's proposals very differently, what they all shared was the eagerness to help the American public and to improve their profession's image. Within the pages of the *American Journal of Psychiatry* it was clear that Kennedy's mission was interpreted as a great opportunity for psychiatry in general and for the individual disciplines in particular. In his 1964 address to the American Psychiatric Association, President C. H. Hardin Branch called Kennedy's interest in mental health "dramatic and heart-warming" and called on psychiatrists "to match the mountains of opportunity now arising out of the plains of apathy and disinterest" that he felt had previously characterized public awareness of mental illness.[150] Following Kennedy's assassination, the Council of the American Psychiatric Association intensified its commitment to Kennedy's scheme, saying that he was the "first President of the United States to champion the cause of the mentally ill" and that "[i]t must be our faith that the realization of the President's dream of a wholly new approach to mental illness would abate the very violence which struck him down. It must be our tribute to him that we quicken our resolve to make that dream come true."[151] After the passage of the "Oswald Bill" and the provision of unprecedented resources, the American psychiatric community felt prepared to address the ambitious mission set forth to them by their assassinated president.

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[150] Branch, "Presidential Address," *American Journal of Psychiatry*, 3.
[151] Council of the American Psychiatric Academy, "A Tribute to John Fitzgerald Kennedy," *American Journal of Psychiatry*, Vol. 120 (1963/1964), an unnumbered addendum between pp. 728 and 729.

There were many convincing reasons for American psychiatry to accept Kennedy's great challenge. Most importantly, solving the nation's psychiatric woes would contribute substantially to silencing the critics who appeared to surround American psychiatry on all sides. Historian Gerald Grob has shown that American psychiatry had been consistently criticized since its origins in the nineteenth century and continued to be marginalized, understaffed, and under-funded during the post-war period.[152] Despite being described by both themselves and historians as being the most beleaguered and derided of the medical professions,[153] by the 1960s the profession had been summoned by the late president to solve the most urgent health problem facing the nation.[154] The president's support came at a crucial time for American psychiatry when all psychiatric disciplines were facing serious pressures from factions within and outside of the profession. While the anti-psychiatry movement attacked various psychiatric philosophies and practices from an academic perspective, psychiatrists like Seymour L. Halleck and Milton H. Miller recognized that mainstream America also questioned the methods of psychiatrists.[155]

If the large number of articles and letters in the *American Journal of Psychiatry* are any indication, American psychiatrists were most concerned about the threat posed to

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[152] Grob, *From Asylum to Community*, 279, 51.

[153] Howard P. Rome, at one time a president of the American Psychiatric Academy, related a personal anecdote that reflected the medical sciences' disdain for psychiatry. When Rome decided to switch his residency from internal medicine to psychiatry in the 1930s, his advisor strongly suggested that he might want to inquire into his own mental health for making such a decision. Rome, Sanford, Smith, Weinstein, and Sullivan, "Psychiatry Viewed from the Outside," *American Journal of Psychiatry*, 519. Gerald N. Grob has described how American psychiatry has fought to answer its critics since the 1870s. Charles E. Rosenberg has described how American psychiatry has struggled to become legitimate. Grob, *Mental Illness and American Society*, 49-62; Rosenberg, *Explaining Epidemics*, 246.

[154] Kennedy, "Message from the President," *American Journal of Psychiatry*, 729.

[155] Milton H. Miller and Seymour L. Halleck, "The Critics of Psychiatry: A Review of Contemporary

them by the anti-psychiatry movement. The basic claim of anti-psychiatrists like Erving Goffman, Michel Foucault, and Thomas Szasz was that the concept of mental illness was a falsehood; insanity was either imagined or contrived to serve the purposes of the individual or the state.[156] In the American context, the most notable anti-psychiatrist of the 1960s and 1970s was Thomas Szasz, a fully trained psychiatrist and libertarian who polemically questioned any intrusion of psychiatry, or the state, into the lives of individuals.[157] This meant that while Szasz lambasted the concept of involuntary psychiatric treatment and institutionalization, he also ridiculed the notion that mental illness could be used as an excuse for socially unacceptable behaviour.[158] American psychiatrists took Szasz's extreme position quite seriously. Not only was he published regularly in *The American Journal of Psychiatry*, his aggressive stance against the legitimacy of psychiatry and the concept of mental illness attracted dozens of letters to the editor. Szasz's views spearheaded the libertarian and right wing attack on psychiatry, including some right wing politicians who feared that "[m]ental health programs [were] a part of a communist plot to control people's minds."[159] Americans from the right of the political spectrum also attacked the "foreign (i.e. Jewish?) and supposed sexual and political liberalism" of psychoanalysis.[160]

Critical Attitudes," *American Journal of Psychiatry*, Vol. 119 (1962/1963), 706.

[156] Goffman, *Asylums*; Foucault, *Madness and Civilization*; Szasz; *Myth of Mental Illness*.

[157] Miller and Halleck, "The Critics of Psychiatry," *American Journal of Psychiatry*, 706.

[158] Thomas Szasz, *The Therapeutic State: Psychiatry in the Mirror of Current Events* (Buffalo, New York: Prometheus Books, 1984).

[159] Alfred Auerback, "The Anti-Mental Health Movement," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 106.

[160] Brackets included in the original. Norman Dain, "Antipsychiatry," in Roy W. Menninger and John C. Nemiah (eds.) *American Psychiatry after World War II, 1944-1994* (Washington, D.C.: American Psychiatric Press, 2000), 289.

American psychiatry was also targeted by members of the political left.[161] Michel Foucault's *Madness and Civilization*, while addressing institutionalization in seventeenth and eighteenth-century France, enticed American historians like David J. Rothman to explore the concept of deviance and social conformity.[162] Echoing charges that the Soviet Union habitually "diagnosed" political prisoners as being insane and institutionalized them indefinitely, American anti-psychiatrists and radical psychiatrists claimed that mainstream psychiatry existed to coerce Americans into docile conformity.[163]

Mainstream America was also sceptical of psychiatry. As contemporary psychiatrists Milton H. Miller and Seymour L. Halleck described, "the psychiatrist has probably both the most prestige and is at the same time the most highly criticized person on the American professional scene."[164] The reasons for the public's disenchantment with psychiatry included the high cost of state psychiatric hospitals, the abuse and neglect of patients, and the dire side effects of heroic treatments such as lobotomies, electroshock therapy, insulin shock therapy, and pharmacotherapy. As Pressman has described, these therapies, which had been tolerated, if not supported in the 1940s and early 1950s, were condemned by the late 1950s and 1960s, as psychoanalysis dominated American psychiatry and criticisms of psychiatry grew.[165] No specific psychiatric field was above

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[161] Paul Lowinger, "Psychiatrists Against Psychiatry," *American Journal of Psychiatry*, Vol. 123 (1966/1967), 492.
[162] Foucault, *Madness and Civilization*; David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, (Boston: Little, Brown, and Company, 1971).
[163] Talbott, "Radical Psychiatry," *American Journal of Psychiatry*, 121-122.
[164] Miller and Halleck, "The Critics of Psychiatry," *American Journal of Psychiatry*, 705.
[165] Pressman, *Last Resort*, 365-367.

reproach.[166] Psychoanalysts, on the one hand, were often perceived to be merely esoteric and too expensive to ever meet the average American's mental health needs.[167] Biological psychiatry, scarcely a decade removed from the horrors of lobotomies, electro-convulsive therapy, and insulin shock treatment, the latter two of which were still supported by articles in psychiatric journals,[168] could be seen to have a decidedly darker image. The support of a progressive, liberal, and Democrat president who simultaneously acted assertively, and at times, aggressively to protect American national interests, was a boon to a profession that was often disparaged by critics from both ends of the political spectrum.

Despite the differences in their attitudes towards psychiatry and the rationales for their opinions, critics of psychiatry from the right and left and supporters of the profession, like Kennedy, had one important belief in common. Specifically, they and a large percentage of the American population, whether or not they trusted the profession, believed that psychiatrists had tremendous power to significantly harm or improve society.[169] In other words, when Kennedy challenged American psychiatry to heal America's psyche, most citizens believed that however misguided psychiatrists might be they indeed had the ability to foment enormous societal change.[170] According to psychiatrist J. Martin Myers, this belief was reflected, and to a certain degree,

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[166] Miller and Halleck, "The Critics of Psychiatry," *American Journal of Psychiatry*, 705.
[167] Robert H. Felix, "The Image of the Psychiatrist: Past, Present, and Future," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 319.
[168] Leonard Cammer, "Treatment Methods and Fashions in Treatment," *American Journal of Psychiatry*, Vol. 118 (1961/1962), 448; Patrick Flynn and Solomon Hirsch, "Antidepressants and Electroshock," *American Journal of Psychiatry*, Vol. 119 (1962/1963), 577; Leonard Cammer, "Reply to the Foregoing," *American Journal of Psychiatry*, Vol. 118 (1961/1962), 1057.
[169] Harvey J. Tompkins, "The Presidential Address: The Physician in Contemporary Society," *American Journal of Psychiatry*, Vol. 124 (1967/1968), 1-2.

constructed, in the image of the psychiatrist presented in the media, film, and literature. Myers was concerned that psychiatrists were viewed as omniscient supermen who gave the public unrealistic expectations of what they could actually accomplish.[171] Many American psychiatrists, representing all fields, also believed in this image and had faith that, if given the resources, they would be able to heal society.[172]

Nevertheless others were concerned that the challenge presented to them by Kennedy was simply impossible to meet. According to psychiatrists Lawrence Sharpe and Leon Eisenberg, the rush to pursue President Kennedy's goals was in reality "an unseemly scramble to board the federal gravy train, [a] situation [that] is patently absurd, since none of the specialties (including our own) has a wholly admirable record and since the size and nature of the need exceeds the capacities of each of the specialties."[173] In other words, the professional and financial possibilities presented by Kennedy's plan, as well as the faith placed in them by politicians and the public, made American psychiatrists over-confident and vulnerable to a disastrous fall from grace. If the great expectations Kennedy and other Americans had in psychiatry came to naught, so too would psychiatry's opportunity to gain medical and scientific respectability. Many psychiatrists feared that their profession would continue to be a second-class medical field that had to clamour for prospective students and grovel for respect from the

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[170] Grob, *From Asylum to Community*, 4.

[171] J. Martin Myers, "The Image of the Psychiatrist," *American Journal of Psychiatry*, Vol. 121 (1963/1964), 326. There were times when Hollywood was more sceptical, however. One example of the vicissitudes involved in according psychiatrists too much authority comes from the Hitchcock film, *Anatomy of a Murder* (1959). A young psychiatrist, without any ill intention, is able to convince a jury that a defendant in a murder case is innocent by reason of insanity. By the end of the film, however, it is clear that he has made a terrible mistake.

[172] Myers, "The Image of the Psychiatrist," *American Journal of Psychiatry*, 326.

[173] Lawrence Sharpe and Leon Eisenberg, "Child Psychiatry; Mental Deficiency," *American Journal of*

scientific community. Despite these fears, however, each psychiatric field accepted Kennedy's challenge and strove, independent of one another, to provide the solution to America's mental health problems.

The biological psychiatric approach to hyperactivity eventually overshadowed those put forth by social psychiatrists and psychoanalysts not because it was more scientific, but rather because it was more pragmatic, marketable, and socially relevant. Using historian Jack Pressman's lock and key analogy, biological psychiatry's key, or approach to hyperactivity, was a great deal more adept at opening the lock represented by hyperactivity than the keys of either of its rivals. This contention will be substantiated by unravelling how each field came to understand and deal with the perception that hyperactivity was an important psychiatric problem for American children and youth. The strengths and weaknesses of each approach will be compared to those of the others, starting with social psychiatry. Social psychiatry is explored first because it was the most promising approach during the 1960s, especially following President Kennedy's support of preventative psychiatry in his "Message to Congress." The story of psychoanalysis and hyperactivity in this chapter is sandwiched between those of social and biological psychiatry chiefly because, during the 1960s and 1970s, the legitimacy of psychoanalysis, the most authoritative field in psychiatry during the 1950s and 1960s, was similarly pressured and strained due to attacks from both of these opposing fields. Biological psychiatry's experience with hyperactivity concludes the chapter as it is the field that eventually succeeds in discrediting social and psychoanalytic psychiatry and dominating psychiatric knowledge about hyperactivity in the 1980s.

Psychiatry, Vol. 120 (1963/1964), 652.

Social Psychiatry, Social Hygiene, and Hyperactivity

Biological psychiatry's dominance over other psychiatric fields by the late 1970s was not entirely predictable on February 5, 1963, when John F. Kennedy's message to the United States Congress was announced. Although biological psychiatry would eventually benefit the most from President Kennedy's mental health plan, the psychiatric field with the most to gain initially from the president's approach to mental illness, and, therefore, the biggest threat to psychoanalytic hegemony, was social psychiatry.[174] Kennedy's emphasis on eliminating the environmental causes of mental illness, especially poverty, mirrored the preventative strategies of social psychiatry.[175] His vision for American psychiatric services also stressed less reliance on massive, isolated state hospitals, criticized by Kennedy as a kind of "social quarantine," and, instead, a shift towards more numerous, smaller, and localized community mental health centres.[176] While biological psychiatrists facilitated this move, by providing drugs, such as anti-psychotics and tranquilizers, that allowed more psychiatric patients to move out of state hospitals and back into their home communities, and psychoanalysts often treated these prodigal patients, the new community focus was based on the philosophies of social psychiatry.

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[174] Kennedy, "Message from the President," *American Journal of Psychiatry*, 729.

[175] Kennedy, "Message from the President," *American Journal of Psychiatry*, 733-734. Kennedy believed that mental retardation was also caused by social conditions and could be prevented. In his message to Congress, he cited statistics that draft rejections for mental retardation were fourteen times higher in poor neighbourhoods as compared to those in wealthy neighbourhoods. Moreover, while only one to two percent of children in wealthy neighbourhoods were considered mentally retarded, the rates for poor neighbourhoods ranged from ten to thirty percent. Although these numbers probably reflect ethnocentric and class-biased assessment measures, they do illuminate Kennedy's belief that mental retardation, like other mental problems, was rooted in socioeconomic conditions and was preventable. Kennedy, "Message from the President," *American Journal of Psychiatry*, 733-734.

[176] Kennedy, "Message from the President," *American Journal of Psychiatry*, 730-732.

The basic idea behind social psychiatry in the 1960s was that mental illness was primarily caused by socio-economic factors and, therefore, could be prevented by more distributive economic policies and socially responsible government programs.[177] Studies emerging during the 1960s that linked poverty and adverse social conditions with mental illness supported this idea.[178] Social psychiatrists also blamed mental illness on the stresses aroused by rapid technological advances and such global problems as overpopulation, pollution, war, and pestilence.[179] Since these massive, complicated problems would not be easily or quickly solved, social psychiatrists urged their colleagues to work in the communities most affected by them. The most significant symbol of this philosophy was the rise of the community mental health centres. Although community mental health centres were initiated with funding from the National Institute of Mental Health, private funding was expected gradually to replace federal funding after five years.[180] Gerald Grob has argued that the community mental health centres were part of a public health effort to integrate "decent and humane care with access to medical services."[181] This shift in policy originated, according to Grob, out of the psychiatric

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[177] Albert J. Solnit, "Who Deserves Child Psychiatry? A Study in Priorities," *Journal of the American Academy of Child Psychiatry*, Vol. 5, (1966), 7-8.
[178] Henry W. Brosin, "Response to the Presidential Address," *American Journal of Psychiatry*, Vol. 124 (1967/1968), 7; Hersch, "Child Guidance Services," *Journal of the American Academy of Child Psychiatry*, 229-230; Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Academy of Child Psychiatry*, 531.
[179] Seymour L. Halleck, "The Psychiatrist and Youth: Joint Efforts Toward Innovative Solutions," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1768-1769.
[180] Steven S. Sharfstein, "Will Community Mental Health Survive in the 1980s?" *American Journal of Psychiatry*, Vol. 134 (1977), 1363.
[181] Grob, *From Asylum to Community*, 304.

profession's experience treating combat-induced psychiatric disorders on the battlefield and the emergent belief that psychiatric care could be best provided in the community.[182]

Community mental health centres were designed to play a number of roles in social psychiatry's preventative strategy towards mental illness. Community mental health centres would facilitate research into mental health by providing insight into how each community's mental health was affected by the social factors specific to its situation.[183] They would also allow psychiatrists to work closely with other allied health professionals, including psychiatric social workers, school guidance counsellors, and community health nurses. Although many psychiatrists reacted negatively to this suggestion, others, including those representing the Council of the American Psychiatric Association, believed that cooperating and sharing responsibilities with allied health professionals was a necessity.[184] Social psychiatrists, in particular, felt that increased collaboration would lead to a universal, socially based understanding of mental health problems. While this may be seen as an effort by social psychiatrists to unite interdisciplinary beliefs about mental illness, it should also be viewed as an ambitious strategy to emphasize the supremacy of social psychiatric knowledge. The causes of juvenile delinquency, for example, would no longer differ for a psychologist (who might blame a personality problem), a pediatrician (who might blame a physical problem), or a teacher (who might blame a learning problem).[185] The social problems affecting the community in which the juvenile delinquent belonged would become the crucial factor

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[182] Grob, *From Asylum to Community*, 304.
[183] Hersch, "Child Guidance Services," *Journal of the American Academy of Child Psychiatry*, 229-230.
[184] Council of the American Psychiatric Academy, "Position Statement on Psychiatry of Adolescence," *American Journal of Psychiatry* Vol. 123 (1966/1967), 1031.

for social psychiatrists and all of the allied health professionals to consider. The patient for social psychiatry was not an individual person, but the community as a whole.[186]

For some, social psychiatry's explanation for mental illness and prophylactic measures of eliminating poverty and social injustice lacked scientific evidence and was unrealistic, but during the 1960s these strategies reflected the theoretical beliefs of many psychiatrists, and especially child psychiatrists.[187] Many presidents of the American Psychiatric Association during the 1960s, including Daniel Blain, C. H. Hardin Branch, Henry W. Brosin, Jack R. Ewalt, and Raymond W. Waggoner, Sr. supported the tenets of social psychiatry and urged the psychiatric profession to study the pathological effects of social problems.[188] Indeed, social psychiatric theory and the "drastic" social changes promoted by it[189] were less extreme than biological psychiatric theories that supported lobotomies, electro-convulsive therapy, and insulin shock treatment or some aspects of Freudian psychoanalysis.

Moreover, the Joint Commission on the Mental Health of Children, a task force created following the passage of the "Oswald Bill," emphasized the socio-economic conditions faced by children as being the key factor in the prevention of mental illness.[190]

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[185] Cunningham, "The American Academy," *Journal of the American Academy of Child Psychiatry*, 20.
[186] Leonard J. Duhl, "Dr. Duhl Replies," *American Journal of Psychiatry*, Vol. 123 (1966/1967), 710.
[187] Donald L. Shapiro, "The Psychiatrist and the Problem of Social Control," *American Journal of Psychiatry*, Vol. 127 (1970/1971), 1098.
[188] Blain, "The Presidential Address; Novalescence," *American Journal of Psychiatry*, 4; Branch, "Presidential Address," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 10; Brosin, "Response to the Presidential Address," *American Journal of Psychiatry*, 7; Ewalt, "The Future of Psychiatry," *American Journal of Psychiatry*, 980; Raymond W. Waggoner Sr. "The Presidential Address: Cultural Dissonance and Psychiatry," *American Journal of Psychiatry* Vol. 127 (1970/1971), 1.
[189] Leo H. Bartemeier, "The Future of Psychiatry: The Report on the Joint Commission on Mental Illness and Health," *American Journal of Psychiatry*, Vol. 116, (1959/1960), 980.
[190] American Psychiatric Academy, "Position Statement on *Crisis in Child Mental Health: Challenge for the 1970's*, the Final Report of the Joint Commission on Mental Health of Children," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1197-1203.

Reginald S. Lourie, who headed the Joint Commission, was willing to "recommend a radical reconstruction of the present [psychiatric] system" in order to solve the nation's mental health problems.[191] Commenting on the Joint Commission, the American Psychiatric Association agreed that a new child-respecting society was needed and that the recommendations of the Joint Commission would "strengthen the nation's resolve and capacity to deal with its awesome problems."[192] Joseph D. Noshpitz, an associate editor for the *Journal of the American Academy of Child Psychiatry*, posited that successful societies invested substantially in children and echoed the American Psychiatric Association's plea to American national interests by contending that the mental health of children should be the government's primary commitment.[193] Even outside observers like Judge David L. Bazelon, who served on the Joint Commission, concurred that the mental health needs of children were best served by providing healthy homes and improved schools.[194]

Psychiatry's interest in social problems, however, was not a mere reflection of contemporary political sentiment. Instead, social psychiatric theory, while it reflected many of the socially progressive ideals of the 1960s, was also based on markedly utilitarian aims.[195] Specifically, as psychiatrists, politicians, and the American public in general grew increasingly alarmed about the numbers of mentally troubled children, it became clear that psychotherapy, the predominant therapeutic strategy during the 1950s

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[191] Lourie, "The Joint Commission," *American Journal of Psychiatry*, 1281.
[192] American Psychiatric Academy, "Position Statement," *American Journal of Psychiatry*, 1197-1198.
[193] Noshpitz, "Toward a National Policy," *Journal of the American Academy of Child Psychiatry*, 390.
[194] Bazelon,"The Problem Child," *Journal of the American Academy of Child Psychiatry*, 199.
[195] Kennedy, for example, mentioned in his message to Congress that his arguments were based on both compassion and utility. Kennedy, "Message from the President," *American Journal of Psychiatry*, 737.

and 1960s, could not be the only solution. Quite simply, psychotherapy was impractical. It was expensive, time-consuming, and there were nowhere near enough psychotherapists to treat the millions of children believed to be afflicted by or at risk of mental illness,[196] conservatively calculated in 1962 to be seven to twelve percent of the sixty million American children under fourteen.[197] There were "extraordinary numbers of emotionally disturbed children in the country....and the vast majority of children currently needing clinical care [did] not receive it."[198] Furthermore, many psychiatrists argued that even if there were enough psychoanalysts, the efficacy of psychotherapy, compared to that of other treatments (or no treatment at all), had not been established.[199]

Therefore, of the millions of children thought to have mental problems, only ten percent (and usually the ten percent from the wealthiest families)[200] received the psychiatric care they needed.[201] These forecasts were made more alarming by the belief that psychiatry, like other professions such as law, engineering and education,[202] was failing to attract enough new blood.[203] Child psychiatry in particular, which only emerged as a distinctive field in the 1940s and 1950s, was not attracting its share of

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[196] Nyla J. Cole, C.H. Hardin Branch, and Roger B. Allison, "Some Relationships Between Social Class and the Practice of Dynamic Psychotherapy," *American Journal of Psychiatry*, Vol. 118 (1961/1962), 1004.
[197] Solnit, "Who Deserves Child Psychiatry?" *Journal of the American Academy of Child Psychiatry*, 4.
[198] Charles Hersch, "The Clinician and the Joint Commission Report: A Dialogue," *Journal of the American Academy of Child Psychiatry* Vol. 10 (1971), 411.
[199] Cole, Branch, and Allison, "Some Relationships," *American Journal of Psychiatry*, 1004.
[200] Bazelon, "'The Problem Child'" *Journal of the American Academy of Child Psychiatry*, 193.
[201] Hersch, "Child Guidance Services," *Journal of the American Academy of Child Psychiatry*, 224.
[202] Ewalt, "The Future of Psychiatry," *American Journal of Psychiatry*, 977.
[203] Kenneth E. Appel, "The Future of Psychiatry: The Report on the Joint Commission on Mental Illness and Health," *American Journal of Psychiatry*, Vol. 116, (1959/1960), 974; James S. Eaton, Jr., and Leonard S. Goldstein, "Psychiatry in Crisis," *American Journal of Psychiatry*, Vol. 134 (1977), 743. Anonymous, "The Current Psychiatric Revolution," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 509.

medical students who chose psychiatry for their residency.[204] As a result, parents seeking psychiatric services for their children were stymied by long waiting lists and uncertain results when they finally reached the front of the queue.[205]

Devising preventative strategies, therefore, seemed to be the essential component of a comprehensive plan to eradicate mental illness.[206] Since social psychiatrists were most concerned with the socio-economic causes of mental illness, the social environment in which children were raised was a primary concern for them. This was certainly the case for social psychiatry's approach to hyperactivity. Psychiatrists were expected to identify the disorder's social causes and mobilize politically in order to eradicate them. In this way, the social psychiatrists of the 1960s and 1970s resembled the mental hygienists of the Progressive Era, in essence, determining that society was pathological and then actively lobbying for change. While the "social hygienists" of the latter period were much more morally liberal than their sometimes reactionary Progressive Era counterparts, both movements were primarily preventative and idealistic, believing that the social causes of mental illness could in fact be eliminated. As it happened, the environmental factors thought by social psychiatrists to cause hyperactivity were similar to those that caused other developmental problems like learning difficulties and delinquency. Therefore, hyperactivity was to be prevented in the same manner as

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[204] Daniel H. Funkenstein, "The Problem of Increasing the Number of Psychiatrists," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 862; Reginald Lourie, "The History of the American Academy of Child Psychiatry," *Journal of the American Psychiatric Academy*, Vol. 1 (1962), 196; Oscar B. Markey, "Bridges or Fences," *Journal of the American Academy of Child Psychiatry*, Vol. 2 (1963), 377.

[205] Edward J. A. Nuffield, "Child Psychiatry Limited: A Conservative Viewpoint," *Journal of the American Academy of Child Psychiatry*, Vol. 7 (1968), 220-221.

[206] Duhl, "Dr. Duhl Replies," *American Journal of Psychiatry*, 709; Benjamin H. Balsher et al, "Predicting Mental Disturbance in Early Adolescence," *American Journal of Psychiatry*, Supplement Vol. 121 (1964-1965), XI.

psychiatric ailments, namely, by eliminating the environmental causes like poverty, crime, and familial instability.

By the 1960s, psychiatric research showed that children brought up in poverty and exposed to vices, such as petty crime, prostitution, and violence, were much more likely to be impulsive and distractible in school and succumb to mental illness later on in life.[207] Housing shortages and overcrowding (and the resulting lack of privacy for both children and their parents) were also thought to lead to similar childhood behaviour problems.[208] By the 1960s and into the 1970s, extensive social psychiatric research had indeed raised questions about poverty, ethnicity, and hyperactive behaviour.[209] Psychiatrists were beginning to realize that hyperactivity was most commonly diagnosed in poor children, often representing marginalized visible minorities.[210] Furthermore, a 1978 study on the epidemiology of "hyperkinetic syndrome," another term for hyperactivity, found that not only were rates higher in the United States than in the United Kingdom, but rates in impoverished London communities were higher than that on the more prosperous Isle of Wight.[211] Although the author did admit that the conservatism of British psychiatrists might have contributed to fewer diagnoses overall, he also intimated that socio-economic discrepancies played a major role.

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[207] George E. Gardner, "Aggression and Violence - the Enemies of Precision Learning in Children," *American Journal of Psychiatry*, Vol. 128 (1971/1972), 446; Charles A. Malone, "Some Observations on Children of Disorganized Families and Problems of Acting Out," *Journal of the American Academy of Child Psychiatry*, Vol. 2 (1963), 22-23.

[208] Grootenboer "The Relation of Housing," *American Journal of Psychiatry*, 471.

[209] Stella Chess, Alexander Thomas, and Herbert G. Birch, "Behavior Problems Revisited: Findings of an Anteroperspective Study," *Journal of the American Academy of Child Psychiatry*, Vol. 6 (1967), 330.

[210] Irving N. Berlin, "Some Models for Reversing the Myth of Child Treatment," *Journal of the American Academy of Child Psychiatry*, Vol. 14 (1975), 84.

[211] Graham, "Epidemiologic Perspectives," *Journal of the American Academy of Child Psychiatry*, 197-200.

Even psychiatrists who advocated a pharmaceutical approach to child psychiatry and hyperactivity, such as Edwin A. Goldstein and Leon Eisenberg, believed that "[t]he severe and chronic deprivation experienced by the pre-delinquent child can only be dealt with by large scale forceful community efforts."[212] Eisenberg was also concerned that he and other psychiatrists had "neglected prevention in our preoccupation with treatment,"[213] a view that reflected Kennedy's beliefs about improving mental health.[214] In relation to hyperactivity specifically, Eisenberg stressed that "[m]uch of the difficult behaviour seen in association with brain damage syndrome [a 1960s term for hyperactivity] stems not from the anatomical deficits, but from the social consequences of personality development."[215] Subsequent biological psychiatrists, such as Dorothy Otnow Lewis, also acknowledged in the late 1970s that hyperactive children from affluent families received more support than those from poorer families.[216]

Similarly, many psychoanalysts believed that the anxieties associated with poverty and the discrimination faced by minorities made children more susceptible to ego dysfunction and subsequent problems like impulsivity and distractibility.[217] Psychoanalyst Eleanor Pavenstedt, the inaugural editor for the *Journal of the American Academy of Child Psychiatry*, stressed the need for more research on the effects of

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[212] Edwin A. Goldstein and Leon Eisenberg, "Child Psychiatry; Mental Deficiency," *American Journal of Psychiatry*, Vol. 121 (1964-1965), 655-656.
[213] Leon Eisenberg, "Discussion of Dr. Solnit's Paper 'Who Deserves Child Psychiatry? A Study in Priorities,'" *Journal of the American Academy of Child Psychiatry*, Vol. 5 (1966), 23.
[214] Kennedy, "Message from the President," *American Journal of Psychiatry*, 730.
[215] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Academy of Child Psychiatry*, 530.
[216] Dorothy Otnow Lewis, "Psychobiological Vulnerability to Delinquency: Introduction A Historical Perspective," *Journal of the American Academy of Child Psychiatry*, Vol. 17 (1978), 195.
[217] I.N. Berlin, "The Atomic Age, the Nonlearning Child, the Parent," in I.N. Berlin and S.A. Szurek (eds.) *Learning and its Disorders: Clinical Approaches to Problems of Childhood* (Palo Alto, California: Science

poverty, substance abuse, prostitution, violence, and crime on the ego development.[218] Likewise, psychoanalyst Charles A. Malone stated that "disorganized" family situations characterized by brutality, alcoholism, illegitimacy, crime, delinquency, and neglect led to "acting out" (a term used by psychoanalysts to describe the symptoms of hyperactivity). Malone believed that in this "normless world" impulses like petty crime, prostitution, public urination, and fighting are not fantasized by children, but actually carried out.[219] If children raised in poverty happened to avoid mental illness, their own children would similarly be at risk, unless they were able to break out of the cycle of poverty. Therefore, social psychiatrists encouraged their colleagues to advocate public housing projects, better education, and employment programs in order to prevent mental illness among society's disadvantaged.[220]

As a result, the social psychiatrist's role was as much political as it was medical.[221] For many, like John P. Spiegel and Henry W. Brosin, the 1968/1969 American Psychiatric Association president, it was the psychiatrist's duty to get politically involved and fight for social justice.[222] Criticizing biological psychiatry, Brosin added in his presidential address to the Association that the American people "need[ed] ideals, not drugs, for healing [their] dissatisfactions and bruised egos."[223] Others, while they supported the etiological rationale for social psychiatry, disagreed that psychiatrists should have to become so active. Oscar B. Markey, for example,

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and Behavior Books 1965), Vol. I, 65-66.

[218] Pavenstedt, "Introduction to the Symposium," *Journal of the American Academy of Child Psychiatry*, 8.

[219] Malone, "Problems of Acting Out," *Journal of the American Academy of Child Psychiatry*, 22-23.

[220] Solnit, "Who Deserves Child Psychiatry?" *Journal of the Academy of Child Psychiatry*, 8.

[221] Duhl, "Dr. Duhl Replies," *American Journal of Psychiatry*, 711.

[222] John P. Spiegel, "Social Change and Unrest: The Responsibility of the Psychiatrist," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1581-1582; Brosin, "Response," *American Journal of Psychiatry*, 7.

complained that "society seems to expect the psychiatrist to take full responsibility for curing troubled and troublesome youth, when the primary burden must remain with society."[224] Moreover, conservative psychiatrists, such as Edward J. A. Nuffield, disagreed with the notion that psychiatrists should spend their time working on social issues. Nuffield believed that instead, psychiatrists should concentrate on discovering the biological components of human development and forsake the community for the laboratory.[225]

Nuffield's concern highlighted a debate recognized by social psychiatrists about how psychiatrists chose whom they should treat. Despite the rich psychopathology presented by the poorer segments of society, increasing numbers of psychiatrists in private practice were reluctant to engage with the poor for financial reasons and decided to treat wealthier patients instead.[226] Research into this phenomenon inferred that psychiatrists preferred treating patients with whom they identified (those who were educated and wealthy) rather than the poor or even the working class who were often referred to psychiatric social workers.[227] Although troubled children also provided a potentially abundant supply of patients, psychiatrists failed to turn their gaze towards children until the late 1950s.[228] Not surprisingly, children with behaviour problems were especially difficult for psychoanalysts, who required patients to be calm and introspective. The treatment of juvenile delinquents, for example, was so "woefully disappointing that

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[223] Brosin, "Presidential Address," *American Journal of Psychiatry*, 14.
[224] Markey, "Bridges or Fences," *Journal of the American Academy of Child Psychiatry*, 375.
[225] Nuffield, "Child Psychiatry Limited," *Journal of the American Academy of Child Psychiatry*, 220-221.
[226] Hersch, "Child Guidance Services," *Journal of the American Academy of Child Psychiatry*, 226.
[227] Cole, Branch, and Allison, "Some Relationships," *American Journal of Psychiatry*, 1006-1009.
[228] Henry H. Work, "Career Choice in the Training of the Child Psychiatrist," *Journal of the American Academy of Child Psychiatry*, Vol. 8 (1969), 442.

[psychoanalysts were] inclined to avoid treating them" and "[a]ttempts to treat these patients almost always fail[ed]."[229] For social psychiatry, the preferences of individual psychiatrists were a moot point compared to the needs of citizens in the communities most affected by mental illness. Agreeing with this contention, and remembering psychiatry's vulnerability to public criticism, C. H. Hardin Branch, the president of the American Psychiatric Association, acknowledged in 1964 that American society expected psychiatrists to address social problems and warned that psychiatry's standing in the community was determined by how it met the community's needs.[230]

Branch's views notwithstanding, social psychiatry's approach to preventing hyperactivity, as with its approach to all other mental disorders, required an enormous amount of political, social, and economic change at all levels of government. Its prevention also required the widespread support of the public at large.[231] Although social psychiatry was well respected during the 1960s and factored clearly in President Kennedy's mental health initiative, the preventative strategies it put forth were ambitious, idealistic, and revolutionary, especially when applied without the supplementary support of psychoanalytic and biological psychiatric strategies. Kennedy's plan had suggested that a significant degree of co-operation between the three major psychiatric fields was necessary, but this co-operation was never realized. If social psychiatry's preventative strategies were effectively conjoined with, instead of set up against, the therapeutic aspects of psychoanalysis and pharmacotherapy, a more pluralistic understanding of

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[229] Sidney Berman, "Techniques of Treatment of a Form of Juvenile Delinquency, the Antisocial Character Disorder," *Journal of the American Academy of Child Psychiatry*, Vol. 3 (1964), 24.
[230] Branch, "Presidential Address: Preparedness for Progress," *American Journal of Psychiatry*, 10.
[231] Sidney Berman, "The Relationship of the Private Practitioner of Child Psychiatry to Prevention,"

hyperactivity and other mental illnesses might have been achieved. The social, emotional, and physiological history of the child presenting the symptoms of hyperactivity would be investigated and considered when psychiatrists made treatment decisions. Without this support, however, social psychiatric theories appeared to be based on the naïve visions of a remote utopia.

One of the primary factors in social psychiatry's decline in the 1970s, and thus its minimal impact on the development of theories regarding hyperactivity, was the revolutionary tinge to its theoretical underpinnings. Advocates pressed that a wholesale change to the structure of American society was required in order to eliminate disorders like hyperactivity. Unfortunately, as psychiatrist (and tacit supporter of social psychiatric theory) Albert J. Solnit noted, politicians, not psychiatrists, had the power to prevent the environmental causes of mental illness.[232] More importantly in terms of reflecting how contemporary psychiatrists felt about social psychiatry, Solnit (quoting poet Robert Lowell) admitted that "[o]ne side of me is a conventional liberal, concerned with causes, agitated with peace and justice, and equality....My other side is deeply conservative, wanting to get at the root of things."[233] In other words, while many psychiatrists were convinced that improved social conditions was an efficacious psychiatric policy and supported social justice in general, most were unwilling to commit as fully to social psychiatry as the field demanded. Concurrently, as the 1960s ended and the 1970s began, psychiatrists, and the American public in general, became more pessimistic about

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Journal of the American Academy of Child Psychiatry, Vol. 12 (1974), 594.

[232] Solnit "Who Deserves Child Psychiatry?" *Journal of the American Academy of Child Psychiatry*, 7.

[233] Solnit "Who Deserves Child Psychiatry?" *Journal of the American Academy of Child Psychiatry*, 2.

society's prospects for progress.[234] Psychiatrists feared that the 1970s would bring, at best, tumult and turmoil, if not chaos to American society and its mental health.[235]

By the 1970s social psychiatry was even beginning to lose those who had both morally and financially supported its tenets. The promises psychiatrists made during the 1960s seemed increasingly difficult to fulfill as the resources available then dried up during the 1970s.[236] Indicative of this trend was Henry Brosin's "The Presidential Address" to the American Psychiatric Association in 1968/1969. In his "Response to the Presidential Address" the year before, Brosin supported the tenets of social psychiatry, saying that the prospects of reducing poverty and improving health and education looked promising.[237] A year later, Brosin's presidential comments were much more cautious. He noted that American involvement in Vietnam was drawing resources away from mental health programs and that pragmatic choices must be made.[238] Other fiscal constraints, especially inflation and the energy crisis of the early 1970s, tightened purse strings of the now Republican government. Quoting John W. Gardner, the Secretary of State for Health, Education, and Welfare, Brosin indicated that a "crunch between expectations and resources" was occurring.[239] Although social psychiatrists would contend that the investment in prevention that they advocated would prove to be

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[234] Rome, Sanford, Smith, Weinstein, Sullivan "Psychiatry Viewed from the Outside," *American Journal of Psychiatry*, 519-530.
[235] Leonard J. Duhl, "The Psychiatrist's Role in Dealing with Social Turmoil," *American Journal of Psychiatry*, Vol. 127 (1970/1971), 226.
[236] Ben Bursten, "Psychiatry and the Rhetoric of Models," *American Journal of Psychiatry*, Vol. 136 (1979), 664.
[237] Brosin, "Response to the Presidential Address," *American Journal of Psychiatry*, 7.
[238] Brosin, "Presidential Address," *American Journal of Psychiatry*, 5.
[239] John W. Gardner in Brosin, "The Presidential Address," *American Journal of Psychiatry*, 5.

economically sound in the future, this was an investment that a fiscally stretched American society was unwilling to make.

Resources notwithstanding, other commentators doubted the efficacy of focussing so heavily on preventative strategies targeting the poor. Psychiatrist Daniel Cappon, for example, was quite pessimistic regarding the prospects of preventing mental illness. Although Cappon thought that community psychiatry might indeed humanize the inner cities, he also believed that the shift from isolated psychiatric hospital to local community mental health centre was primarily a geographical, rather than an ideological shift for psychiatry.[240] In an oddly alliterative, yet nevertheless serious critique of social psychiatry's faith in human nature, psychoanalytically oriented psychologist Charles Hersch argued that "[t]he community control concept has been presented as the panacea for the present plight of the poor. But in its practice the poverty population persistently portrays the same proclivities towards power politics that previously has been the prerogative of the privileged."[241] Hersch went on to state that social psychiatry's approach to both poverty and its relation to mental illness was simplistic, naïve, and completely disregarded the importance of the unconscious.[242] As the social optimism of the 1960s began to fade, so too did faith in the mental health strategies that relied upon it.

Other factors contributing to social psychiatry's demise during the 1970s included the rejection of social psychiatry's broad definition of psychiatry and the roles of the psychiatrist. For example, many psychiatrists, representing both psychoanalytic and

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[240] Daniel Cappon, "The Present Status of Prevention in Psychiatry," *American Journal of Psychiatry*, Vol. 126 (1969/1970), 1008-1009.
[241] Hersch, "A Dialogue," *Journal of the American Academy of Child Psychiatry*, 413.
[242] Hersch, "A Dialogue," *Journal of the American Academy of Child Psychiatry*, 413.

biological psychiatric backgrounds, eschewed the idea that psychiatrists were at all knowledgeable about social problems or meant to spend large amounts of their time in political, rather than medical activities. Psychiatrist Jacob Schwartz expressed this contention in a letter to the editor of *The American Journal of Psychiatry*. Schwartz argued that psychiatrists ought not to be social activists and added that by claiming to be experts about social problems, social psychiatrists were cruelly misleading the American public about their abilities to prevent mental illness.[243] In another letter, Robert M. Eisendrath echoed Schwartz's concern and added that psychiatrists should not be asked to raise money for complex social issues that were outside of the realm of psychiatry and medicine.[244] Concern about the true realm of psychiatry was also expressed in a 1971 symposium on the social role of psychiatrists and the American Psychiatric Association. While Leon Eisenberg contemplated the potential power of a psychiatric lobby group in Washington to encourage positive change and help to prevent childhood psychiatric disorders, Herbert C. Modlin declared that psychiatrists had no business venturing from their traditional role.[245] Commentators outside of the psychiatric profession, such as Harvard historian H. Stuart Hughes, also felt that the political roles assigned to psychiatrists by social psychiatry were inappropriate and dangerous to the health of the

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[243] Jacob Schwartz, "Role of the Psychiatrist," *American Journal of Psychiatry*, Vol. 124 (1967/1968), 1267.

[244] Robert M. Eisendrath, "A Lack of Zip and Sense of Gold," *American Journal of Psychiatry*, Vol. 123 (1966/1967), 708.

[245] Irving Philips, Herbert C. Modlin, Irving N. Berlin, Leon Eisenberg, Howard P. Rome, and Raymond W. Waggoner, "The Psychiatrist, the APA, and Social Issues: A Symposium," *American Journal of Psychiatry*, Vol. 128 (1971/1972), 680-684.

profession as a whole because they would create expectations that psychiatrists would not be able to meet.[246]

Fearing the financial health of their clinics and loyal to the concept of medical free enterprise, psychoanalysts with private practices were often very critical of social psychiatric theory. While some, like Sidney Berman, felt simply that private clinicians should be consulted by social psychiatry regarding their role in preventing mental illness in children, others were much more acidic.[247] Following a letter to the editor by Henry A. Davidson that encouraged private practitioners to donate time to community clinics, a number of angry responses were subsequently published in *The American Journal of Psychiatry*.[248] The vast majority of respondents stressed that such "Robin Hood" notions undermined the economic interests of psychiatrists and "den[ied] elementary economic and political facts of life." Others felt that the work they did at community health centres as psychiatric residents was equal to more than their share of volunteer work.[249] Although the president of the American Psychiatric Association, Jack R. Ewalt, hoped that these psychiatrists represented the minority, it is clear that many resented social psychiatry and its egalitarian aims.[250]

Linked to the financial worries of private clinicians was the growing confusion about how psychiatric work should be defined. Role confusion intensified during the 1960s with three remarkably distinct psychiatric fields vying for supremacy.[251]

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[246] Hughes, "Emotional Disturbance and American Social Change," *American Journal of Psychiatry*, 27.
[247] Berman, "Private Practitioner," *Journal of the American Academy of Child Psychiatry*, 595-596.
[248] Davidson, "Correspondence," *American Journal of Psychiatry*, 795.
[249] Henry A. Davidson, "Comment: The Reversible Superego," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 192.
[250] Jack R. Ewalt, "The President's Page," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 505.
[251] Fritz Redlich and Stephen R. Keller, "Trends in American Mental Health," *American Journal of*

Discrepancies about the precise definition of psychiatry were not a new phenomena; the previous century had seen psychiatrists whose approaches to the same problem were completely different. The respective theories of the biologically inclined Emil Kraepelin and the analytical Carl Gustav Jung with regards to dementia praecox during the turn of the century provide a good example of how far apart contemporary psychiatric theories on the same topic could be.[252] Social psychiatry provided a second dimension to the continuum that stretched between the extreme variations of biological and psychoanalytic psychiatry. Although biological psychiatrists and psychoanalysts would debate back and forth about the medical and scientific validity of their respective theories, they did agree that the work done by social psychiatrists devalued the psychiatric profession.[253] While psychoanalysts charged that social psychiatry was "watered down and ineffective," biological psychiatrists claimed that it retreated from the medical model of psychiatry.[254]

Social psychiatry was criticized for its methodology, as well as its theoretical basis. Not only did social psychiatrists encourage political activism, they also recommended much closer ties with other allied health professionals such as community health nurses, psychiatric social workers, and school guidance counsellors. Some social psychiatrists, like Leo H. Bartemeier, recommended that psychiatry adopt a much more liberal attitude towards what counted as psychiatric treatment and who could provide it.[255] The involvement of such professions in providing psychiatric services, as well as

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Psychiatry, Vol. 135 (1978), 28.

[252] Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), 184-185, 194.

[253] Hersch, "A Dialogue," *Journal of the American Academy of Child Psychiatry*, 410.

[254] Melvin Sabshin, "The Anti-Community Health 'Movement,'" *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1007.

[255] Bartemeier "The Future of Psychiatry," *American Journal of Psychiatry*, 978.

their rapid growth in the previous two decades,[256] understandably perturbed many psychiatrists.[257] Psychoanalysts were concerned about the suggestion that social workers, psychologists, and even teachers were quite capable of providing psychoanalysis.[258] Those who specialized in treating children, whose work often involved liaising with allied health professionals, were especially concerned that they would lose the authority they enjoyed in these relationships.[259] As Oscar B. Markey exclaimed, "[m]ay the blurring of the boundaries between us and our professional allies clear away completely."[260] Other psychoanalysts, like Elwyn M. Smolen and Stanley Rosner, thought that it was simply inefficient to have such professional redundancy in community mental health centres, but this point was used as part of the authors' underlying argument about psychiatric power within the centres.[261] Since these centres relied on the collaboration between psychiatrists and allied health professionals, they lost a great deal of the support that they had enjoyed during the 1960s, as psychiatrists questioned the sharing of psychiatric authority in the centres and elsewhere.[262]

Psychiatrist T.P. Millar, for example, was concerned about the notion that teachers might be able to provide psychoanalytic services to children.[263] This would be

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[256] Ironically, the shortage of psychiatrists contributed substantially to the increase in the number of allied health professionals or "para-medical professionals" who provided psychiatric services. Redlich and Keller, "Trends," *American Journal of Psychiatry*, 27.
[257] Markey, "Bridges or Fences," *Journal of the American Academy of Child Psychiatry*, 377.
[258] Eisenberg, "Discussion of Dr. Solnit's Paper," *Journal of the American Academy of Child Psychiatry*, 20.
[259] Rexford, "Child Psychiatry," *Journal of the American Academy of Child Psychiatry*, 365, 375.
[260] Markey, "Bridges or Fences," *Journal of the American Academy of Child Psychiatry*, 380.
[261] Elwyn M. Smolen and Stanley Rosner, "Observations on the Use of a Single Therapist in a Child Guidance Clinic," *Journal of the American Academy of Child Psychiatry*, Vol. 2 (1963), 354.
[262] Frank T. Rafferty, "Community Mental Health Centers and the Criteria of Quantity and Universality of Services for Children," *Journal of the American Academy of Child Psychiatry*, Vol. 14 (1975), 5.
[263] Reflecting contemporary assumptions about gender and vocation, Millar was also careful to describe teachers as being female and psychiatrists as being male. This is despite the fact that the editor of the

especially true for a popular disorder like hyperactivity that tended to be identified in schools. If teachers were allowed to diagnose hyperactivity and provide various forms of therapy, then psychiatrists would be placed in a position where they would have to share, rather than monopolize, psychiatric authority. Although Millar did not state where teachers would find the time to provide such a service, his concern reflected that of many other psychiatrists regarding their control over psychiatric knowledge and practices.

All of these factors contributed to social psychiatry's demise as a viable vehicle through which to address the mental health concerns of Americans. Despite the endorsement of social psychiatry by President Kennedy and many high profile American psychiatrists, as well as its relevance to the progressive attitudes of the 1960s, the impracticality of its complex and revolutionary remedy for hyperactivity and other mental illnesses prevented it from becoming a viable treatment alternative. While social psychiatry's approaches to hyperactivity and other mental illnesses was beginning to be supported by research results that demonstrated how poverty and related social ills contributed to mental illness,[264] social psychiatry's preventative socio-economic remedies were nearly impossible to employ, difficult to substantiate through scientific trials, and unlikely to satisfy those seeking an immediate solution, namely children with hyperactivity, their families, and their psychiatrists. As a result, social psychiatric theories about mental illness faded from the pages of the major psychiatric journals by the

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journal in which he was published was female, namely, Eveoleen N. Rexford. T. P. Millar, "Psychiatric Consultation with Classroom Teachers," *Journal of the American Academy of Child Psychiatry*, Vol. 5 (1966), 134-135.

[264] Berlin, "Some Models," *Journal of the American Academy of Child Psychiatry*, 84; Brosin, "Response to the Presidential Address," *American Journal of Psychiatry*, 7; Hersch, "Child Guidance Services to the Poor," *Journal of the American Academy of Child Psychiatry*, 229-230; Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Academy of Child Psychiatry*,

late 1970s and have not re-emerged as a force within the profession. With the demise of social psychiatry, the psychiatric profession not only lost an important critical voice, but also the major proponent of preventative psychiatry within the profession. The prevention of hyperactivity and other mental illnesses ceased to be a primary focus for psychiatrists and, instead, reactive strategies became the primary way in which psychiatry dealt with mental illness.

The Psychoanalytic Approach to Hyperactivity

If social psychiatry had the most to gain from Kennedy's interest in mental illness, then it is clear that psychoanalysis had the most to lose. The premier position in American psychiatry during most of the 1950s and 1960s unquestionably belonged to psychoanalysis. Psychoanalytic research eclipsed that of other psychiatric fields in the *Journal of the American Academy of Child Psychiatry*, for example, a journal whose editorial staff during the 1960s consisted primarily of psychoanalysts.[265] The following quotation, for example, illustrates the influence of psychoanalysis during the 1960s, but also the fact that this influence was beginning to be questioned by other psychiatrists. The writer, psychiatrist Mark A. Stewart, complains about job advertisements in the American Psychiatric Academy "Mail Pouch" that stress how psychiatrists should be dynamically (psychoanalytically) oriented. Stewart states that "this phenomenon, which unhappily is symptomatic of the general situation of psychiatry today, can make our

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[265] Eveoleen N. Rexford, "A Developmental Concept of the Problem of Acting Out," *Journal of the American Academy, of Child Psychiatry* Vol. 2 (1963), 6-21. A symposium seven years later on youth unrest was similarly psychoanalytically biased. Settlage, "Adolescence and Social Change," *Journal of the American Academy of Child Psychiatry*, 203; Williams, "Alienation of Youth ," *Journal of the American Academy of Child Psychiatry*, 251; Louis J. Wise, "Alienation of Present-Day Adolescents," *Journal of the American Academy of Child Psychiatry*, Vol. 9 (1970), 264.

profession seem ridiculous to other physicians and to scientists in general." Stewart goes on to say that this discriminatory practice could be challengeable in the courts.[266]

To the chagrin of psychiatrists like Stewart, however, most psychiatrists during this time were psychoanalytically trained and psychoanalytic case studies dominated the pages of psychiatric journals. This was especially true of child psychiatrists. In a special series on childhood behaviour problems, or "acting out," for example, all articles were based in psychoanalytic theory, including those by Eveoleen N. Rexford, the series' editor.[267] Psychoanalytic explanations for childhood disorders like hyperkinetic reaction (a 1960s term for hyperactivity) also dominated the *DSM-II* at the expense of those that were biological.[268] For many American psychiatrists there was no "magical belief in some kind of correspondence between psychical processes and central nervous processes."[269] Despite this apparently hegemonic position, psychoanalysis was still threatened by the "wholly new approach" to psychiatry, consisting of a focus on both social and biological psychiatry, espoused by Kennedy in his message to Congress on mental illness and mental retardation.[270] Although psychoanalysts would indubitably

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[266] Mark A. Stewart, "Correspondence: Dynamic Orientation," *American Journal of Psychiatry*, Vol. 117 (1960/1961), 85.

[267] Eugen Kahn, "Whence Now?" *American Journal of Psychiatry*, Vol. 121 (1964/1965), 4441; Nuffield, "Child Psychiatry Limited," *Journal of the American Academy of Child Psychiatry*, 220; Parens and Weech, Jr., "Accelerated Learning Responses," *Journal of the American Academy of Child Psychiatry*, 75.

[268] Richard L. Jenkins, "Classification of Behavior Problems of Children," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1032-1033.

[269] L. Borje Lofgren, "A Comment on 'Swedish Psychiatry,'" *American Journal of Psychiatry*, Vol. 116 (1959/1960), 83-84. Despite his Swedish name, Lofgren was an American who lamented the fact that Swedish psychiatrists were turning away from psychoanalysis in favour of biological approaches. His letter to the editor received a curt reply from Olof Kinberg, a Swedish psychiatrist who believed that it was a compliment to Swedish psychiatry that psychoanalysis was on its way out. Olof Kinberg, "Reply to the Foregoing," *American Journal of Psychiatry*, Vol. 116 (1959/1960), 84.

[270] The Council of the American Psychiatric Academy, "A Tribute to John Fitzgerald Kennedy," *American Journal of Psychiatry*, Supplementary page between pages 728 and 729.

have a part to play in this new approach, the amount of power they would have to share with the other fields was unclear.

If the story of social psychiatry represents how a revolutionary approach proved to be too radical a solution for America's mental health woes, the decline of psychoanalysis in the 1970s demonstrates the failure of the status quo, a field that was already being characterized during the 1970s as a traditional and cautious approach.[271] As social psychiatrists concerned with hyperactivity were hampered by the impracticality of their socio-economic and political agenda, psychoanalysts treating the disorder suffered from having equally impractical solutions, but for completely different reasons. Specifically, if the grand promises of social psychiatry represented the most ambitious approach to hyperactivity, psychoanalysis symbolized the exceptionally modest method. The difficulties psychoanalysts faced in treating hyperactivity symbolize why they were unable to remain the most important branch of psychiatry during the 1970s and 1980s.

Psychoanalytic theory, in contrast to that of social psychiatry, limited its adherents to take on the disorder one case at a time. For psychoanalysts, there was no universally preventative and egalitarian vaccine that could prevent all those at risk of hyperactivity and other mental problems, as there was in social psychiatry. Instead, the etiologies of mental illness, while rooted in Freudian theory, were as numerous as the number of patients. Psychoanalysis, therefore, lacked the scope, simplicity and preventative focus of social psychiatry. Although psychoanalysts could provide guidance to parents, there was precious little hope of preventing mental problems to the extent proposed by social

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[271] Although psychoanalysis only had been prevalent in the United States since the end of the Second World War, it was perceived to be the most conservative branch of psychiatry by the 1960s, largely because

psychiatrists.[272] Social psychiatry's focus on the social and mental health of children also tapped into the American preoccupation during the 1960s with the problems of children and their development. While psychoanalysts were greatly concerned with childhood development, their interest was in using childhood history to unravel the neuroses of adults, not to nip them in the bud.[273] Although there were many psychoanalytic child psychiatrists, they nevertheless took a retrospective approach to their young patients.

Psychoanalysis also lacked the optimism that was inherent in social psychiatric theory. Unlike social psychiatrists, who viewed human nature as being inherently good, but pathologized by the inequities of a Dickensian social structure, psychoanalysts believed that it was the vicissitudes of often banal human development that caused mental illness. The roots of hyperactivity were not found on the overcrowded and filthy streets of the urban American slums, but instead, they were mired in the core of the patient's unconscious. Tapping into this unconscious required the presupposition that although there were certainly patterns of causation, they could not be applied to a particular patient without thorough investigation and individual psychotherapy.

Finally, if social psychiatry viewed human nature as being inherently good, psychoanalysis viewed it as being inherently flawed and in need of a professional's meticulous correction. Psychoanalysts typically found parents culpable for the disorders affecting their children[274] and the actions of parents, whether intentional or not, were

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biological approaches and social psychiatry only gained attention during the 1960s.

[272] Leventhal, "The Significance of Ego Psychology," *Journal of the American Academy of Child Psychiatry*, 248.

[273] Leo Kanner, "Child Psychiatry: Retrospect and Prospect," *American Journal of Psychiatry*, Vol. 117 (1960/1961), 16.

[274] I. N. Berlin, "The Atomic Age," in *Learning and its Disorder*, 64; Adelaide M. Johnson and S. A.

believed by psychoanalysts to be the most important factor in childhood development.[275] For example, psychiatrist Eveoleen Rexford identified the passive aggression and sexual frustrations of fathers as being a cause of acting out, a psychoanalytic term for hyperactivity.[276] Other psychoanalysts, like Joseph D. Noshpitz, believed that children acted out the unresolved and repressed frustrations of their parents, resulting in impulsive and aggressive behaviour.[277] In many cases, psychoanalysts insisted that in order for a hyperactive child's behaviour to improve, parents must also engage in extensive, costly psychotherapy.[278] The psychoanalytic process was, therefore, a painstakingly slow, exorbitantly expensive, and uninspiring solution to hyperactivity.

Regardless of these perceived shortcomings, American psychoanalysts felt obliged to meet Kennedy's challenge and did so with a great deal of enthusiasm. One of the reasons for this is that despite its dominance in psychiatry, psychoanalysis faced increased pressure from social and biological approaches to psychiatry.[279] Social psychiatrists attacked the aloof and elite attitude they saw in psychoanalysts and the inaccessibility of

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Szurek, "The Genesis of Antisocial Acting Out in Children and Adults," in I. N. Berlin and S. A. Szurek (eds.), *Learning and its Disorder: Clinical Approaches to Problems of Childhood* Vol. 1, (Palo Alto, California: Science and Behavior Books, 1965), 136; Rosenberg and Mueller, "Preschool Antisocial Children," *Journal of the American Academy of Child Psychiatry*, 427; Frank J. Menolascino, "The Facade of Mental Retardation: Its Challenge to Child Psychiatry," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 1233.

[275] Johnson and Szurek, "The Genesis of Antisocial Acting Out," in *Learning and its Disorder*, 136.

[276] Rexford, "A Developmental Concept," *Journal of the American Academy of Child Psychiatry*, 16.

[277] Noshpitz, "Certain Cultural and Familial Factors," *American Journal of Psychiatry*, 216.

[278] Frank J. Curran, "To Help the Child, We Must Also Help the Parent," *American Journal of Psychiatry*, Vol. 124 (1967/1968), 1449. Prescott has also found this to be the case in her study of American Child Guidance Centres in the first half of the twentieth century. Heather Munro Prescott, *A Doctor of Their Own: The History of Adolescent Medicine* (Cambridge, Massachusetts: Harvard University Press, 1998).

[279] John Forrester, "A Whole Climate of Opinion: Rewriting the History of Psychoanalysis," in Roy Porter and Mark S. Micale (Eds.) *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994), 183.

psychotherapy to most patients.[280] Psychoanalysis' seemingly unscientific theoretical foundations were vulnerable to attack from more biologically inclined psychiatrists and other physicians who stressed that the causes of mental illness were physiological and best treated with drugs such as the antipsychotic Thorazine (chlorpromazine) and the antidepressant Tofranil (imipramine).[281] Many biological psychiatrists scornfully suggested that since psychotherapy was not founded in physiology, many non-medical professionals, including social workers, psychologists, and psychiatric nurses, could successfully perform it.[282] Psychiatrists from both fields charged that psychoanalytic theory was completely without merit and that it was a waste of time, effort, and resources for any physician to be trained in the practice.[283] Historian Nathan G. Hale, Jr. has also blamed the unwillingness of insurance companies to pay for extended psychotherapy and the wide dissemination of hostile attacks on Freud among intellectuals and the wider public for undermining psychoanalysis.[284] Moreover, as research into pharmacology and neurology increased during the 1950s and 1960s, creating popular psychiatric drugs like Thorazine and Tofranil and gaining the attention of other physicians, psychotherapy seemed to be less necessary.[285]

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[280] Bernard Bandler, "The American Psychoanalytic Academy and Community Psychiatry," *American Journal of Psychiatry*, Vol. 124 (1967/1968), 1037-1038; Hersch, "Child Guidance Services," *Journal of the American Academy of Child Psychiatry*, 224.

[281] Judd Marmor, "The Current Status of Psychoanalysis in American Psychiatry," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 679-680; Kinberg, "Reply to the Foregoing," *American Journal of Psychiatry*, 84; Norman Dain, "Psychiatry and Anti-Psychiatry in the United States," in Roy Porter and Mark S. Micale (eds.) *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994), 430.

[282] Eisenberg, "Discussion of Dr. Solnit's Paper," *Journal of the American Academy of Child Psychiatry*, 20.

[283] Kinberg, "Reply," *American Journal of Psychiatry*, 84; Ekkehard Othmer and Arnold M. Ludwig, "Drs. Othmer and Ludwig Reply," *American Journal of Psychiatry*, Vol. 134 (177), 628.

[284] Hale, Jr., "American Psychoanalysis" in *American Psychiatry*, 96.

[285] William Sargant, "Drugs or Psychotherapy," *American Journal of Psychiatry*, Supplement Vol. 121

Kennedy, on the other hand, implied that there would be a place for psychotherapy and psychoanalysts in his proposed approach. While prevention was stressed in Kennedy's message, millions of dollars were also earmarked for research into the treatment of psychiatric problems. Since psychotherapy was the primary treatment method during the 1960s, psychoanalysts were the beneficiaries of a significant proportion of these research dollars.[286] As such, the legitimacy of psychoanalysis as an authoritative medical field stood to benefit from the President's support. Therefore, psychoanalysts welcomed President Kennedy's plan as a means by which they could stay on the top rung in the psychiatric hierarchy. Unfortunately for the field, the potential pitfalls associated with joining the president's fight against mental illness contributed to its demise.

For psychoanalysts one of these pitfalls was hyperactivity. The struggles psychoanalysts faced treating hyperactivity, especially compared with the successes of biological psychiatrists in relation to the disorder, help to explain why they failed in their attempt to remain the most authoritative, legitimate, and relevant branch of psychiatry. In particular, the relationship between psychoanalysis and hyperactivity illuminates the most pressing conundrums for psychoanalysts, namely, the difficulty in bridging the gap between theory and practice. While psychoanalytical explanations for hyperactivity were often quite logical, blaming stress, trauma, and breakdowns within the family unit for the behaviours characterized by the disorder,[287] it was much more difficult for members of

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(1964/1965), XXVIII.

[286] Kennedy, "Message from the President," *American Journal of Psychiatry*, 733.

[287] Contemporary physician Gabor Maté has stressed these factors in his rather radical reinterpretation of ADHD. Gabor Maté, *Scattered Minds: A New Look at the Origins and Healing of Attention Deficit*

the profession to treat the disorder effectively. Psychotherapy was time consuming, expensive, and often emotionally draining for both patients and their families. Moreover, the psychotherapeutic process required a patient to concentrate, to be reflective, and to follow dutifully the psychotherapist's suggestions. This was an arduous requirement for impulsive, distractible, defiant, and hyperactive children to meet. One psychoanalyst described that her patient's "hyperactivity increased and all in a manner of a few minutes, she sat on my desk, wrote on the blackboard, and picked her nose excessively."[288] Effective psychotherapy was understandably difficult in these conditions. In a market saturated with potential patients and without enough psychoanalysts, many psychiatrists accused psychoanalysts of turning away difficult patients like hyperactive children.[289]

Regardless of the difficulties inherent in treating hyperactive patients, many psychoanalysts researched the disorder, convinced that if they could understand why the behaviour occurred, they would be able to devise effective therapeutic strategies to treat it. Although psychoanalysts agreed on general etiological assumptions about why hyperactive behaviour occurred, specific reasons for why it existed in a particular case were required in order for effective psychotherapeutic treatment. As a result, most of the psychoanalytic articles found in psychiatric journals during the 1960s about hyperactivity were written in the form of case studies featuring the clinical observations of a single

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Disorder (Toronto: Vintage Books, 1999).

[288] Paulina F. Kernberg, "The Problem of Organicity in the Child: Notes on Some Diagnostic Techniques in the Evaluation of Children," *Journal of the American Academy of Child Psychiatry*, Vol. 8 (1969), 537.

[289] Leon Eisenberg, Anita Gilbert, Leon Cytryn, and Peter A. Molling, "The Effectiveness of Psychotherapy Alone and in Conjunction with Perphenazine or Placebo in the Treatment of Neurotic and Hyperkinetic Children," *American Journal of Psychiatry*, Vol. 116 (1959/1960), 1092; Edmund F. Kal, "Organic Versus Functional Diagnoses," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1128; Judith Rapoport, Alice Abramson, Duane Alexander, and Ira Lott, "Playroom Observations of Hyperactive Children on Medication," *Journal of the American Academy of Child Psychiatry*, Vol. 10 (1971), 531; Berman,

patient. The patient would be introduced along with a detailed description of his or her behaviours, personality, history, and family situation. The author would then describe how he was able to unravel the reasons for the patient's hyperactivity and describe the course of psychotherapy. One instance of this is found in the 1960 edition of the *Archives of General Psychiatry* in which the story of "Jean" was told. Jean was a twelve-year-old girl whose impulsive behaviour, her psychiatrist determined, was the result of penis envy stemming from the relationship she had with her father. Jean's impulsive behaviour ceased only when she was able to come to terms with this actuality.[290]

Although each case study described very different situations and root causes for hyperactivity, psychoanalysts also determined some general psychoanalytic conclusions about hyperactivity from their clinical research. In almost all cases hyperactivity was superficially blamed on problems with the child's ego.[291] Superego impairment caused a child's id to dominate the ego, leading to the impulsive behaviours characterized by hyperactivity. Furthermore, psychoanalysis was the only way to free the ego from the unwanted oppression exerted by the uncontrolled id.[292] For example, in a special 1963 symposium published in the *Journal of the American Academy of Child Psychiatry* on "acting out," both Gregory Rochlin and Eveoleen N. Rexford stressed that the impulsivity of hyperactive children was the result of impaired superego development caused by early

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"Techniques of Treatment," *Journal of the American Academy of Child Psychiatry*, 24.

[290] Joseph Weinreb and Robert M. Counts, "Impulsivity in Adolescents and Its Therapeutic Management," *Archives of General Psychiatry*, Vol. 2 (1960), 549-550.

[291] For example, Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Academy of Child Psychiatry*, 529; Leventhal, "The Significance of Ego Psychology," *Journal of the American Academy of Child Psychiatry*, 246; Rosenberg and Mueller, "Preschool Antisocial Children," *Journal of the American Academy of Child Psychiatry*, 436.

[292] Silvano Arieti, "Psychiatric Controversy: Man's Ethical Dimension," *American Journal of Psychiatry*, Vol. 132 (1975), 40.

childhood emotional trauma.[293] The specific reasons for a child's superego impairment, as well as the best manner in which to deal with it, however, had to be determined on a case by case basis. While Jean's superego impairment emerged out of her relationship with her father, the root causes of hyperactivity in other children could originate in the child's weaning, toilet training, or adjustment to a new sibling.[294]

Despite these specific etiological differences, psychoanalytic theories about hyperactivity shared two important commonalities that shaped how they were received by the rest of the psychiatric community. First, psychoanalysts stressed the uniqueness of each hyperactive patient and his or her specific course of therapy.[295] Psychoanalysis provided no magic bullets when it came to preventing or treating hyperactivity, in marked contrast to both social and, as described below, biological psychiatry. Therefore, it was a therapy that required both a great deal of faith in its efficacy and a substantial degree of patience on the part of both the psychoanalyst and her patient.

Second, psychoanalysts during the 1960s described hyperactivity as being a decidedly mental, as opposed to neurological, phenomenon. One fascinating example of this viewpoint is portrayed in psychoanalyst George A. Rogers' suggestion to other psychoanalysts about how they might use methylphenidate, otherwise known as Ritalin, the most commonly prescribed drug for hyperactivity treatment. Rogers hypothesized that the calming and motivating effects of the stimulant on patients might lead to more

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[293] Rochlin, "Observations of Delinquent Behavior," *Journal of the American Academy of Child Psychiatry*, 53; Rexford, Problem of Acting Out," *Journal of the American Academy of Child Psychiatry*, 11.
[294] Alexander Thomas, Herbert Birch, Stella Chess, and Lillian C. Robbins, "Individuality in Responses of Children to Similar Environmental Situations," *American Journal of Psychiatry*, Vol. 116 (1959/1960), 798.
[295] Christoph M. Heinicke and Larry H. Strassmann, "Toward More Effective Research on Child Psychotherapy," *Journal of the American Academy of Child Psychiatry*, Vol. 14 (1975), 569.

efficient psychotherapy.[296] Although Rogers recognized that stimulants obviously affected human behaviour, sometimes for the better, he and his fellow psychoanalysts nevertheless believed that the most effective way of treating the hyperactivity was to address the underlying problem that lay in the patient's subconscious, not the functioning of his neurological system. These two psychoanalytic axioms regarding hyperactivity, that the root cause of hyperactivity was different for each patient and that it was a mental, not a neurological disorder, were the means by which other psychiatrists, primarily those from the biological field, were able to attack and discredit the psychoanalytic approach to hyperactivity.

The inability of psychoanalysts to treat even a small portion of the children diagnosed with hyperactivity in the 1960s and 1970s was due in part to economic factors. There was a paucity of psychoanalysts, but more importantly, very few families could afford the time or money required for psychoanalysis.[297] As Leon Eisenberg explained (commenting on the need for more psychopharmacological research), there were "more people struggling in the stream of life than we can rescue with our present tactics" of psychoanalysis. [298] Although some psychiatrists suggested that group or family therapy might be a good way to make psychoanalysis more efficient, others argued that the strategy was ineffective since each patient's disorder was caused by different factors and

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[296] George A. Rogers, "Methylphenidate Interviews in Psychotherapy," *American Journal of Psychiatry*, Vol. 117 (1960/1961), 549. Some biological psychiatrists also stressed that effective pharmacotherapy was merely a means to the end of improved counselling sessions. S. Wayne Smith, "Trifluoperazine in Children and Adolescents with Marked Behavior Problems," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 703.

[297] Rexford, "Child Psychiatry and Child Analysis," *Journal of the American Journal of Child Psychiatry*, 381.

[298] Eisenberg, "Discussion of Dr. Solnit's Paper," *Journal of the American Academy of Child Psychiatry*, 23.

would require individualized therapy.[299] Regardless, group therapy was not a particularly effective option in the psychoanalysis of hyperactive children. Psychoanalysts had enough difficulty getting one hyperactive patient to focus, let alone half a dozen of them.

Although it was true that results, not theories, were the most important measure of psychiatric success, the theoretical battle between psychoanalysts and biological psychiatrists over hyperactivity was more evenly contested. Biological and psychoanalytic psychiatrists had been arguing about whether the childhood disorder was neurological or mental in origin since the 1960s,[300] but it took until the 1970s for the weight of biological research on hyperactivity to push psychoanalytic case studies out of the pages of American psychiatric journals. One indication of the respect biological psychiatrists had for the power of psychoanalysis during the 1960s was the inclination of many, including Augustus S. Rose, the editor of *The American Journal of Psychiatry*, to accommodate certain psychoanalytical principles into their theories. Rose, although he urged a return to educational practices of the 1930s, when psychiatric residents received a great deal more neurological and anatomical training, felt that the integration of both fields was best for psychiatry.[301] Psychiatrist Herbert G. Birch added that no single scientific field or research strategy could provide a complete understanding of brain

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[299] Solnit "Who Deserves Child Psychiatry?" *Journal of the American Academy of Child Psychiatry* Vol. 5 (1966), 3.
[300] Malone, "Some Observations on Children," *Journal of the American Academy of Child Psychiatry*, 39; *Psychiatry* Vol. 121 (1964-1965), 655-656.
[300] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Academy of Child Psychiatry*, 528.
[301] Augustus S. Rose, "The Integration of Neurology into Psychiatric Education," *American Journal of Psychiatry*, Vol. 123 (1966/1967), 592-594.

damage (a generic term that, for Birch, included hyperactivity).[302] Agreeing with this generalization, C. Keith Conners and Leon Eisenberg stressed that although they supported the prescription of methylphenidate (Ritalin) for children with hyperactivity, they also believed that more studies considering personality were needed.[303]

By the late 1960s the types of articles on hyperactivity published in the major journals indicated that the situation had begun to reverse.[304] Research supporting the pharmaceutical treatment of hyperactivity increasingly flooded psychiatric journals, considerably outweighing the hyperactivity research done by psychoanalysts. The popularity of newly developed antipsychotic and antidepressant drugs encouraged psychiatrists to search for more pharmaceutical solutions to mental illness. Moreover, the drugs that were being developed often targeted "office-based outpatient psychiatry" and were, therefore, in direct competition to the psychotherapy being offered by psychoanalysts.[305] Ironically, the response of many psychoanalysts to this pressure was similar to that of biological psychiatrists during the early 1960s. Specifically, they attempted to compromise. Although some psychoanalysts remained stubbornly defiant about the psychogenic origins of mental illness,[306] others made attempts to reconcile the two fields.[307] Psychiatrist Justin M. Call, stressing that child psychiatry was always

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[302] Herbert G. Birch, *Brain Damage in Children: The Biological and Social Aspects* (New York: Williams and Wilkins Company, 1964), 10-11.
[303] Conners and Eisenberg, "The Effects of Methylphenidate," *American Journal of Psychiatry*, 462.
[304] Marmor, "The Current Status of Psychoanalysis," *American Journal of Psychiatry*, 679.
[305] David Healy, *The Antidepressant Era* (Cambridge, Massachusetts: Harvard University Press, 1997), 65.
[306] Arieti, "Psychiatric Controversy," *American Journal of Psychiatry*, 39-40; Irving Philips, "Research Directions in Child Psychiatry," *American Journal of Psychiatry*, Vol. 137 (1980), 1436-1437.
[307] Multiple causations were also attributed to related childhood disorders and syndromes like mental retardation and autism. William C. Adamson, "Child Guidance Clinics and Mental Retardation: An Emerging Confluence," *Journal of the American Academy of Child Psychiatry*, Vol. 3 (1964), 346; .Menolascino "The Facade of Mental Retardation," *American Journal of Psychiatry*, 1231-1233; John E.

fluctuating between biological and psychogenic explanations, acknowledged that while psychoanalysis had contributed enormously to understanding hyperactivity, neurological studies could also provide some insight into the disorder.[308] Larry B. Silver went further, explaining that both psychogenic and biological explanations for hyperkinetic reaction were possible.[309]

By the 1970s biological psychiatrists no longer needed to compromise, let alone admit that psychoanalysis was a valid form of treatment. Dozens of psychiatric studies were emerging that supported the efficacy of stimulant medication for hyperactivity. This, in turn, led to an increase in the number of prescriptions being issued by psychiatrists to hyperactive children.[310] Nevertheless, other signs of change were also occurring. Presidents of the American Psychiatric Association, for example, were more often of a biological persuasion than in previous years.[311] The most prestigious psychiatric journals increasingly catered to biological based psychiatric research. Another sign of the waning strength of psychoanalysis was that the primary competition to the mainstream neurological understanding of hyperactivity ceased to come from psychoanalysts. Instead, opposition came from fellow biological psychiatrists who either blamed the neurological deficit on other factors (in the case of Ben F. Feingold, food

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Kysar, "The Two Camps in Child Psychiatry: A Report from a Psychiatrist-Father of an Autistic and Retarded Child," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 107.

[308]. Call, "Some Problems and Challenges," *Journal of the American Academy of Child Psychiatry*, 139-141, 149.

[309] Larry B. Silver, "*DSM-II* and Adolescent Psychopathology," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1268; Silver "The Playroom Diagnostic Evaluation," *Journal of the American Academy of Child Psychiatry*, 253-254.

[310] John S. Werry "An Overview of Pediatric Psychopharmacology," *Journal of the American Academy of Child Psychiatry*, Vol. 21 (1982), 3.

[311] Lawrence C. Kolb, "The Presidential Address: American Psychiatry, 1944-1969 and Beyond," *American Journal of Psychiatry*, Vol. 126 (1969/1970), 5; Ewald W. Busse, "The Presidential Address: There Are

additives[312]) or disputed the use of synthetically derived stimulants (for example, Robert C. Schnackenberg who claimed that caffeine had all the benefits of Ritalin without the many side effects[313]). When psychoanalysis was mentioned, it was rarely described in complimentary terms.[314] While some biological psychiatrists chided psychoanalysts for being unscientific and self-absorbed, others blamed the dominance of psychoanalysis during the 1960s, especially in child psychiatry, for retarding what they felt to be the inevitable development of psychotropic drugs for children.[315] Psychoanalysis was no longer thought to be a supplementary field; its presence was believed to be an unwanted, unscientific interlude that harmed the reputation of psychiatry as a legitimate medical pursuit.[316]

Biological psychiatrists also claimed that psychoanalysts shared in their own downfall by not responding effectively enough to the demand for substantive improvements in psychiatric health in the United States. The psychoanalytic obsession with the etiology of mental illness was said to undermine their ability to treat patients as well as their interest in doing so.[317] In other words, the psychoanalyst's psychological interest in exploring the workings of the mind interfered with their medical role and their

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Decisions To Be Made," *Journal of the American Psychiatric Academy*, Vol. 129 (1972), 2;

[312] Ben F. Feingold, *Why Your Child is Hyperactive* (New York: Random House, 1975).

[313] Robert C. Schnackenberg, "Caffeine as a Substitute for Schedule II Stimulants in Hyperkinetic Children," *Journal of the American Academy of Child Psychiatry*, Vol. 130 (1973), 796-798.

[314] Dennis P. Cantwell, "Genetic factors in the Hyperkinetic Syndrome," *Journal of the American Academy of Psychiatry*, Vol. 15 (1976), 214-215; Rapoport, Abramson, Alexander, and Lott, "Playroom Observations of Hyperactive Children," *Journal of the American Academy of Child Psychiatry*, 524; Richard L. Jenkins "More on Diagnostic Nomenclature," *American Journal of Psychiatry*, Vol. 125 (1968/1969), 1603.

[315] Otnow Lewis "Psychobiological Vulnerability to Delinquency," *Journal of the American Academy of Child Psychiatry*, 193-194.

[316] Martin Fleishman, "Will the Real Third Revolution Please Stand Up?" *American Journal of Psychiatry*, Vol. 124 (1967/1968), 1262.

[317] Sargant, "Drugs or Psychotherapy," *American Journal of Psychiatry*, XXVI.

Hippocratic Oath which required physicians to treat patients with empathy and expediency. While psychoanalysts would counter that improving their psychological knowledge was essential to their successful treating of patients, this argument lost credibility along with all other psychoanalytic theories as they lost ground to those of biological psychiatrists in the increasingly biologically based psychiatric journals. Indeed, biological psychiatrists often developed theories only after successful treatment strategies had been established, thus appearing to some psychiatrists to be more committed to treating patients than their psychoanalytic counterparts.[318] The treatment of hyperactivity with stimulants, which continued unabated for over forty years without a clear understanding of why they worked, certainly fit this model.[319]

As the previous pages suggest, the downfall of psychoanalysis was inextricably linked to the rise of biological psychiatry. The growth of the psychiatric pharmaceutical industry, following the development and production of popular antipsychotic and antidepressant drugs, understandably attracted thousands of psychiatrists who searched for the magic bullets that would eradicate mental illness. While wonder drugs were elusive, biological psychiatrists could show how some drugs (such as Ritalin) produced astonishing change in patient behaviour, thus giving hope to emerging researchers. Correspondingly, pharmaceutical companies courted psychiatrists and advertised the wonders of drug therapy in the pages of medical journals.[320] Ironically, the first

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[318] Donald J. Cohen and J. Gerald Young "Neurochemistry and Child Psychiatry," *Journal of the American Academy of Child Psychiatry*, Vol. 16 (1977), 383.
[319] John S. Werry, "The Use of Psychotropic Drugs in Children," *Journal of the American Academy of Child Psychiatry*, Vol. 16 (1977), 452.
[320] Carl Breitner, "Correspondence: Drug Evaluation in Psychiatry," *American Journal of Psychiatry*, Vol. 119 (1962/1963), 481.

advertisements for Ritalin during the early 1960s in prominent medical journals like the *Journal of the American Medical Academy* did not recommend using the drug to treat hyperactivity. Instead, they targeted the use of the stimulant at subdued older patients who needed more pep and energy. Ritalin, approved by the American Food and Drug Administration in 1961, soon became an extremely important drug for pharmaceutical companies. The pharmaceutical company that manufactured the drug, CIBA, made thirteen million dollars from Ritalin in 1971 alone, accounting for fifteen percent of its profits.[321] Moreover, pharmaceutical and other medical developments, supported in turn by a foundation of earlier bio-medical discoveries such as the discovery of DNA and the successful search for a polio vaccine, lent new credence to more empirical, laboratory-based psychiatry. Finally, the American government's Cold War investment in science and subsequent triumphs in space exploration and computer technology encouraged the efficacy of large scale projects and increased "investment in epidemiological, pharmacological, and psychological studies."[322] Biological psychiatry capitalized on the increased emphasis on science at the expense of the supposedly less scientific field of psychoanalysis.

Subsequently, psychiatry as a whole embraced biological interpretations of mental illness and abandoned theories that separated a patient's brain from his mind. No longer was there to be a "twisted thought without a twisted molecule."[323] The most substantive

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[321] Doris Marian Hamner, "Pathologizing Behaviors: The Case of Attention-Deficit/Hyperactivity Disorder," (PhD. diss., Boston University 1998), 17.
[322] Eisenberg, "Discussion of Dr. Solnit's Paper," *Journal of the American Academy of Child Psychiatry*, 21.
[323] John I. Langdell, "Phenylketonuria: Some Effects of Body Chemistry on Learning," *Journal of the American Academy of Child Psychiatry*, Vol. 6 (1967), 166.

example of this paradigm shift was the publication in 1980 of *DSM-III*, the most common psychiatric reference manual in North America for psychiatrists, pediatricians, psychologists, guidance counsellors, and social workers.[324] Ostensibly produced to clarify diagnostic criteria,[325] but in actuality reifying the rise of biological psychiatry,[326] *DSM-III* reinforced biological interpretations for psychiatric problems including Attention Deficit Disorder (ADD), the newly minted term for hyperactivity. ADD was joined by four times as many child psychiatric disorders as there had been in the psychoanalytically based *DSM-II* (1968).[327] The notion, festering since the 1950s, that many American children were pathological was finally cemented into the medical canon.

Another major sign of the shift away from psychoanalysis involved significant changes in how psychiatric research was described. While psychiatric writing of the 1960s was dominated by the case studies and clinical observations of a few patients, by the 1970s it increasingly consisted of the findings of double-blind studies involving dozens or even hundreds of test subjects. This transition, most noticeable in the *Journal*

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[324] Mai Kubota and Takeshi Matsuishi, "Major Revision of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*): Background of the Change and Conceptualization of Mental Disorders," *Journal of Disability and Medico-Pedagogy*, Vol. 7 (2003), 11-13. It is important to note, however, that *DSM-III* did not overtly claim to be a biologically based manual. Instead, it stressed that it was atheoretical. Despite this claim, contemporary critics and subsequent observers agreed that the manual symbolized the "scientific coming of age for psychiatry." Michael Rutter and David Shaffer "DSM-III: A Step Forward or Back in Terms of the Classification of Child Psychiatric Disorders?" *Journal of the American Academy of Child Psychiatry*, Vol. 18 (1979), 372. Moreover, psychoanalysts fought the *DSM-III* Task Force over their exclusion in the editorial process. Much of the controversy revolved around the omission of the term "neurosis," which indicated that a disorder resulted from intrapsychic conflicts. In the final version the word neurosis was all but omitted and when it was used, was enclosed in parentheses. Kutchins and Kirk, *Making Us Crazy*, 44.

[325] Cohen and Young, "Neurochemistry and Child Psychiatry," *Journal of the American Academy of Child Psychiatry*, 395.

[326] Kutchins and Kirk, *Making Us Crazy*; Kubota and Matsuishi, "Major Revision," *Journal of Disability and Medico-Pedagogy*, 11-13. See also footnote 23 above.

[327] Robert L. Spitzer and Dennis P. Cantwell, "The DSM-III Classification of Psychiatric Disorders of Infancy, Childhood, and Adolescence" *Journal of the American Academy of Child Psychiatry*, Vol. 18 (1979), 361.

of the American Academy of Child Psychiatry, not only demonstrates an ideological change in psychiatry, it is also symptomatic of how the profession became more esoteric during the 1970s. Specifically, biologically based research on hyperactivity was much more difficult to understand and criticize. In contrast, psychoanalytic articles about hyperactive behaviour during the 1960s were much more accessible. Such an article would likely consist of a handful of case studies that provided information about the troubled children, their histories, symptoms, treatment plans, and health outcomes in detail. By and large, these articles were narrative in structure, were interesting to read, and while they often included complicated psychoanalytic theory or language, their basic premise was easy to understand.

For example, in the 1969 edition of the *Journal of the American Academy of Child Psychiatry*, ten-year-old "Daniel's" distractible, impulsive, and aggressive behaviour is described by his psychiatrist as being due to his difficulty "coping with intense castration fears."[328] More importantly, Daniel is described comprehensively and compassionately. He is a "pleasant looking, well-built boy" who is intelligent and is "cooperative and self critical" about his behaviour, "perceiv[ing] himself as a damaged boy."[329] When the reader learns that, following psychotherapy, there is a "dramatic drop in [his] deviancies," he or she is compelled to feel encouraged by the boy's progress and confident in his psychiatrist's ability.[330]

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[328] Eva Rosenfeld, Norman Frankel, and Aaron H. Esman, "A Model of Criteria for Evaluating Progress in Children Undergoing Psychotherapy," *Journal of the American Academy of Child Psychiatry*, Vol. 8 (1969), 214-216.

[329] Rosenfeld, Frankel, and Esman, "Model of Criteria," *Journal of the American Academy of Child Psychiatry*, 214-219.

[330] Rosenfeld, Frankel, and Esman, "Model of Criteria," *Journal of the American Academy of Child Psychiatry*, 219.

In comparison, the typical article on hyperactivity during the 1970s involved the meticulous description of a particular drug trial, involving a great deal of statistical analysis, complicated methodological details, and very little in terms of theoretical conclusions.[331] The findings, whether conclusive or inconclusive, were usually described as being merely a small piece in a seemingly infinite puzzle. Aesthetics aside, it is highly likely that this transformation in how psychiatric research was conducted and written discouraged many psychiatrists and other physicians from reading, let alone debating the findings of a particular study, unless they were involved in similar research. On the other hand, since psychoanalytic research was readable, comprehensible, and conclusive, it was much easier for psychiatrists in a variety of fields (including other psychoanalysts), as well as other physicians and allied health professionals to criticize it.

This vulnerability to criticism, as well as the heterogeneous approach psychoanalysts took to hyperactivity, made it nearly impossible for them to synthesize a concise, rudimentary, and reassuring solution for the disorder onto which the American public could latch. The failure of psychoanalysis to provide a feasible solution to hyperactivity is symbolic of the field's difficulty in responding to the perceived mental health needs of Americans in the 1960s and 1970s. Correspondingly, the biological understanding of hyperactivity developed during the 1970s and made authoritative during the 1980s depended to a large extent on the failure of the psychoanalytic response to the disorder. When viewed through the eyes of a hyperactive child and his parents, psychoanalysis was slow, expensive, and emotionally invasive, especially compared to

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[331] L.M. Greenberg, M.A. Deem, and S. McMahon, "Effects of Dextroamphetamine, Chlorpromazine, and Hydrozine on Behavior and Performance in Hyperactive Children," *American Journal of Psychiatry*, Vol.

efficient, inexpensive, and non-judgemental pharmacotherapy. It required a great deal of patience and faith, as well as a willingness to accept blame for the problem. For the psychiatric profession, psychoanalysis could not logistically address the alarming pandemic of hyperactivity and it ignored the exciting developments in neurology and pharmacology. It also appeared to be an approach that championed theoretical understanding over efficacious patient treatment. In sum, psychoanalytical treatment of hyperactivity proved to be unattractive for both patients and most psychiatrists and with its demise, the biological explanation for the disorder remained.

Perpetual Revolution: The Biological Coup in Psychiatry

It is difficult to overemphasize how revolutionary the biological turn in American psychiatry was during the 1970s. Psychoanalysis reigned supreme during the 1950s and 1960s as the preeminent psychiatric field and psychoanalysts were more concerned about competition from social, rather than biological psychiatry. During the early 1960s psychiatrists were unsure about the extent to which biological factors played a role in mental illness. For instance, Walter E. Barton's words about organic factors in mental illness during his 1962/1963 Presidential Address to the American Psychiatric Association highlight the limited role biology played in contemporary etiological theories about mental illness. Attempting to demonstrate how mental illness could be caused by biological factors, Barton could only provide the example of depression in patients following the administration of steroids.[332] A year later psychiatrist H. Houston Merritt

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129 (1972), 539.

[332] Barton "Presidential Address: Psychiatry in Transition," *American Journal of Psychiatry*, 4.

acknowledged that it was difficult to determine if and how neurology was connected to mental illness.[333]

Less than a decade later, however, Lawrence C. Kolb, the 1969/1970 president of the American Psychiatric Association, would state in his presidential address that within the next generation of psychiatrists, the brain would be perfectly mapped and that this accomplishment would lead to extremely precise pharmaceutical treatment of mental illness.[334] The American Psychiatric Association president during 1972, Ewald W. Busse, also underlined the importance of physiological approaches in his address.[335] Biological psychiatrists could comfortably claim that common disorders like hyperactivity were not only based in neurology, but also most likely genetic and best treated with stimulant medication. In vivid contrast to the social psychiatrists who had been so influential a decade before, biological psychiatrist John S. Werry noted in 1977 that "child psychiatry… [was] not simply a humanitarian exercise, but an applied biological science."[336] Five years later Werry underlined this contention by saying that he was interested in only human biology, not human behaviour.[337]

Indeed, biological psychiatry was based on the theory that the only way to understand human behaviour was to understand human biology. According to biological psychiatrists, mental illness was caused by neurological or biochemical impairments or imbalances that were either genetic or acquired and could be managed most effectively by

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[333] H. Houston Merritt, "Recent Advances in Neurology Significant to Psychiatry," *American Journal of Psychiatry*, Vol. 120 (1963/1964), 456.
[334] Kolb, "The Presidential Address," *American Journal of Psychiatry*, 5.
[335] Busse, "The Presidential Address," *American Journal of Psychiatry*, 2.
[336] Werry, "Psychotropic Drugs in Children," *Journal of the American Academy of Child Psychiatry*, 463.
[337] Werry, "An Overview," *Journal of the American Academy of Child Psychiatry*, 8.

prescribing drugs. The research conducted by biological psychiatrists was rooted in medicine and was characterized as empirical, objective, and quantifiable.[338] Many psychiatrists embraced biological psychiatry because it was perceived to be more scientific and, therefore, more legitimate than its social and psychoanalytical counterparts.

Although the writings of George Frederick Still in 1902 are typically cited as the first medical recognition of hyperactivity, as well as the first biological explanation for such behaviour, psychiatrists Seija Sandberg and Joanne Barton have shown that a number of descriptions of hyperactive children appeared in earlier childhood literature.[339] The most notable precursor to Still was T.S. Clouston, who believed that "simple hyperexcitability" was hereditary and best treated with large doses of bromides, a good diet, and plenty of "suitable amusement, companionship, and employment" in the outdoors.[340]

An encephalitis outbreak during 1917/1918 raised the profile of theories that hyperactive behaviour was caused by brain trauma. Children who survived the outbreak were found to be hyperactive, distractible, and impulsive and the term "postencephalitic behaviour disorder" was used to describe their condition.[341] During the 1930s and 1940s subsequent research suggested that brain injury and hyperactivity were linked, but other findings hinted that the problem was congenital.[342]

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[338] Bursten, "Psychiatry and the Rhetoric of Models," *American Journal of Psychiatry*, 662.
[339] Seija Sandberg and JoanneBarton, "Historical Development," in Seija Sandberg (ed.) *Hyperactivityand Attention Disorders of Childhood* (Cambridge: Cambridge University Press, 2002), 4.
[340] Sandberg and Barton, "Historical Development," in *Hyperactivity*, 5.
[341] Sandberg and Barton, "Historical Development," in *Hyperactivity*, 2.
[342] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Psychiatric Academy*, 529.

Following the Second World War, biological interpretations of hyperactivity in the United States developed in a number of phases. The biological explanation for hyperactivity during the postwar years was that it was caused by "minimal brain damage," which could be caused by anything from a blow to the head to a serious infection or inflammation of the brain.[343] One of the strongest proponents of the minimal brain damage (although he disagreed with adding the qualifier, minimal) was Herbert G. Birch who, in his *Brain Damage in Children: The Biological and Social Aspects*, stressed that maladaptive behaviours never occurred without some kind of brain damage.

Although brain damage persisted as a causative factor in hyperactivity (and still does), research during the 1960s began to indicate that not all hyperactive children had histories of brain damage.[344] By 1971, "minimal brain dysfunction" had replaced "minimal brain damage," although there existed a great deal of overlap in terminology, and genetic explanations for hyperactivity began to be favoured by biological psychiatrists.[345] Minimal brain dysfunction afflicted "children of near average, average, or above average general intelligence with certain learning or behavioural disabilities ranging from mild to severe, which are associated with deviations of function of the central nervous system."[346] As the definition implied, many children could potentially be labelled with minimal brain dysfunction.

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[343] Schrager, Lindy, Harrison, McDermott, and Wilson, "The Hyperkinetic Child," *Journal of the American Psychiatric Academy*, 529.

[344] John S. Werry, Gabrielle Weiss, Virginia Douglas, and Judith Martin, "Studies on the Hyperactive Child III: The Effect of Chlorpromazine upon Behavior and Learning Ability," *Journal of the American Academy of Child Psychiatry*, Vol. 5 (1966), 293.

[345] Cantwell, "Genetic Factors," *Journal of the American Academy of Child Psychiatry*, 214-216.

[346] Leventhal, "The Significance of Ego Psychology," *Journal of the American Journal of Child Psychiatry*, 242.

In 1971 a major shift in how minimal brain dysfunction was understood by biological psychiatrists occurred when Virginia Douglas postulated that attention deficits, not hyperactivity, represented the core behaviour represented by children with the condition. Douglas' research led to the term Attention Deficit Disorder (ADD), the term used in *DSM-III* (1980). Children with ADD who were hyperactive were called ADDH, Attention Deficit Disorder with Hyperactivity. Nevertheless, hyperactivity was later re-instituted as a key aspect of the disorder with the publication of *DSM-IV* (1994).

It is important to note that although biological psychiatry had a long history of investigating hyperactivity, up until the late 1950s, the research was sporadic, consisting of approximately two articles per decade, and concentrated on small numbers of children, usually confined to mental institutions. More importantly, biological explanations for hyperactivity were by no means authoritative. First, as the paucity of research conducted before the late 1950s indicates, hyperactivity was not believed to be a particularly vexing problem until the 1960s. Second, when hyperactivity emerged as a major problem, psychoanalytical explanations for the disorder were predominant and social psychiatric theories also demanded a great deal of attention.

For biological psychiatry to emerge as the authoritative voice on hyperactivity within psychiatry during the mid-1970s, certain factors had to be in place. Most important was the ability of biological psychiatrists to successfully treat the symptoms of hyperactive children with stimulant drugs. A biological psychiatrist only needed an hour to diagnose hyperactivity and prescribe a drug that noticeably reduced hyperactive behaviour almost immediately, thus achieving the impressive results desired by both

psychiatrists and patients.[347] Such a perception of success contributed significantly to this shift in psychiatric understanding. Nevertheless, biological psychiatrists merely treated the disorder and made no claims to cure or prevent it, as their social and psychoanalytic rivals did. Moreover, the stimulant treatment of hyperactivity was not perfect. Stimulant effectiveness faded with time, requiring increasingly larger doses and was efficacious for only four out of every five patients.[348] When dealing with millions of diagnosed children, the twenty percent for whom stimulants failed to work amounted to a substantial population of untreated patients. Nevertheless, stimulant treatment of hyperactivity became, for biological psychiatrists, a model example of how psychotropic drugs might be beneficial to children.[349]

One of the explanations for this development is that by the time tranquilizers like Miltown and anti-psychotics like Thorazine were synthesized in the late 1950s, biological psychiatrists had been using stimulants to treat hyperactivity for two decades.[350] Following Charles Bradley's 1937 article in *The American Journal of Psychiatry* on the efficacy of using stimulants (in this case prescribing Benzedrine to youth confined to a mental institution), a trickle of scientific articles emerged in the 1940s and 1950s on the subject.[351] Likewise, child psychiatrists often prescribed stimulants during this period,

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[347] Indeed, the effect of a stimulant on hyperactive behaviour proved to be a common diagnostic tool for psychiatrists (and still is today). If the stimulant worked, then the child was deemed to be hyperactive. If it did not work, then the root cause of the hyperactive behaviour was often thought to be something else. Huey, Zetin, Janowsky, and Judd, "Adult Minimal Brain Dysfunction and Schizophrenia," *American Journal of Psychiatry*, 1563.

[348] Leon Tec, "An Additional Observation on Methylphenidate in Hyperactive Children," *American Journal of Psychiatry*, Vol. 127 (1970/1971), 1424.

[349] Werry, "Psychotropic Drugs in Children," *Journal of the American Academy of Child Psychiatry*, 452.

[350] Conners and Eisenberg, "The Effects of Methylphenidate," *American Journal of Psychiatry*, 458.

[351] Conners and Eisenberg, "The Effects of Methylphenidate," *American Journal of Psychiatry*, 458. According to one of Bradley's close friends, M.W. Laufer, M.D., Bradley discovered the efficacy of

albeit for children with severe behaviour problems who often resided in asylums.[352] Although it took the pathologization of hyperactivity for stimulant research to explode in the 1960s, the biological psychiatrists interested in addressing what was perceived to be an alarming problem had a solid base from which to proceed.

There were good reasons for stimulant therapy to survive throughout the 1940s and 1950s. The pharmaceutical treatment of hyperactivity was quick, inexpensive, simple, and the same for most patients. By the time the three major psychiatric fields began competing for pre-eminence in the 1960s, other aspects of the biological treatment of hyperactivity helped the cause of biological psychiatrists. Unlike social and psychoanalytic psychiatry, the biological solution to hyperactivity brought psychiatry closer to the rest of medicine in terms of how it researched, explained, and treated mental illness. Ironically, however, child psychiatry's reunion with mainstream medicine also meant that pediatricians and even general practitioners began to annex the child psychiatrist's role of diagnosing disorders like hyperactivity and prescribing medication. This, in turn, contributed to the popularization of the disorder and claims by the 1970s that it was over-diagnosed by overzealous physicians.[353]

Nevertheless, the biological approach to hyperactivity was successful because it simultaneously provided people affected by the disorder and biological psychiatrists with

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stimulants after using Benzedrine to treat the headaches of the young patients at the small hospital he directed. The medication failed to reduce the severity of headaches, but teachers at the hospital noted that many children taking the stimulant experienced notable improvements in their learning, especially in mathematics (the pills were subsequently nicknamed "math pills" at the hospital). Bradley's subsequent clinical trials of the stimulant were positive, but few followed his example until the early 1960s. Mortimer D. Gross, "Origin of Stimulant Use for Treatment of Attention Deficit Disorder," *American Journal of Psychiatry*, Vol. 152 (1995), 298-299.

[352] Werry, "Psychotropic Drugs in Children," *Journal of the American Academy of Child Psychiatry*, 452.

[353] Call, "Some Problems and Challenges," *Journal of the American Academy of Child Psychiatry*, 152.

what they desired. Patients and their families were given the simple, yet apparently effective treatment for hyperactive behaviour that they wanted[354] and biological psychiatrists received reassurance about the efficacy of pharmacotherapy and encouragement that their profession could and should be reunited with mainstream medicine.[355] Furthermore, biological psychiatry could claim that pharmacotherapy was the true legacy of President Kennedy's crusade for mental health. While social psychiatrists and psychoanalysts failed to respond effectively to the presidential challenge, biological psychiatrists, for better or worse, revolutionized psychiatry by bringing it back to the heart of medical science.

Biological psychiatrists also set up their study of the disorder in such a way that faults with their own approach could be overlooked by both physicians and the public. The short cuts made for the professional security desired by biological psychiatrists and simple solutions sought by hyperactive individuals and their families, in other circumstances, might have been deemed serious enough to question the entire biological approach to hyperactivity. First, in the rush to treat the millions of American children diagnosed with hyperactivity, psychiatrists, patients, and their families were reluctant to ask why millions of children were being deemed to be pathological in the first place. The typical biological psychiatric explanation during the 1970s, that hyperactivity was genetic,[356] did not, on its own, explain the recent explosion in the number of diagnoses

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[354] Bazelon, "'The Problem Child'?" *Journal of the American Academy of Child Psychiatry*, 194.
[355] Werry, "An Overview," *Journal of the American Academy of Child Psychiatry*, 3.
[356] Cantwell, "Genetic Factors in the Hyperkinetic Syndrome," *Journal of the American Academy of Child Psychiatry*, 216; Klaus K. Minde and Nancy J. Cohen, "Hyperactive Children in Canada and Uganda: A Comparative Evaluation," *Journal of the American Academy of Child Psychiatry*, Vol. 17 (1978), 486. James H. Satterfield, Dennis P. Cantwell, Leonard I. Lesser, and Robert L. Podosin, "Physiological Studies of the Hyperkinetic Child," *American Journal of Psychiatry*, Vol. 128 (1971/1972), 1418.

and most biological psychiatrists took the cautious approach of stating that the etiology of hyperactivity was heterogeneous.[357] Even Richard L. Jenkins, a psychiatrist firmly committed to the biological treatment of hyperactivity, admitted that etiological explanations for hyperactivity could only be made conclusively in small minority of children, primarily those who had sustained a brain injury.[358] Moreover, social psychiatrists and psychoanalysts could argue that the poverty and domestic discord that ran in families, rather than genetics, was the true cause of hyperactivity. Similarly, biological psychiatrists had a great deal of difficulty explaining the perplexing paradox of why stimulants like methylphenidate, various amphetamines, and even caffeine calmed hyperactive children and improved their attention spans.[359]

Second, the biological psychiatrists who supported stimulant therapy overlooked the side effects associated with their use in children, or at least determined that they were not severe enough to stop prescribing these drugs. The typical side effects of Ritalin, the most commonly prescribed stimulant, included growth inhibition, irritability, insomnia, anorexia, and heart rate changes.[360] These side effects were believed by other concerned

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[357] Leventhal, "The Significance of Ego Psychology," *Journal of the American Academy of Child Psychiatry*, 242; Silver "The Playroom Diagnostic Evaluation," *Journal of the American Academy of Child Psychiatry*, 241.

[358] Jenkins, "More on Diagnostic Nomenclature," *American Journal of Psychiatry*, 1603.

[359] Silver, "The Playroom Diagnostic Evaluation of Children," *Journal of the American Academy of Child Psychiatry*, 253; Schnackenberg, "Caffeine as a Substitute," *Journal of the American Academy of Child Psychiatry*, 796-798; Werry "The Use of Psychotropic Drugs," *Journal of the American Academy of Child Psychiatry*, 453.

[360] Philip Firestone, Jean Davey, John T. Goodman, and Susan Peters, "The Effects of Caffeine and Methylphenidate on Hyperactive Children," *Journal of the American Academy of Child Psychiatry*, Vol. 17 (1978), 446; Barry D. Garfinkel, Christopher D. Webster, and Leon Sloman, "Methylphenidate and Caffeine in the Treatment of Children with Minimal Brain Dysfunction," *American Journal of Psychiatry*, Vol. 132 (1975), 723. It is important to note that one of the reasons Ritalin was (and still is) so popular is that though its side effects were serious, they paled in comparison to that of other stimulants like D-amphetamine, anti-depressants, and tranquilizers. Joel Zrull, Jack C. Westman, Bettie Arthur, and Dale L. Rice, "A Comparison of Dizepam, D-amphetamine, and Placebo in the Treatment of the Hyperkinetic

psychiatrists, however, to be serious enough to warrant the development of a number of intriguing and, at times, drastic alternatives to using drugs like Ritalin. There was a concerted effort by psychiatrists like Robert C. Schnackenberg to prescribe coffee instead of synthetic stimulants. Caffeine's chemical structure was nearly identical to that of methylphenidate (Ritalin),[361] and Schnackenberg recognized that hyperactive individuals who went undiagnosed often self-medicated with coffee and that hyperactivity was much rarer in countries where children typically drank coffee.[362] A less pragmatic solution was that of psychiatrists Seymour Furman and Anne Feighner who, also concerned about side effects, recommended installing closed circuit televisions in homes and schools and training parents and teachers in the practice of video feedback as a creative strategy.[363] Ignoring or ridiculing these alternatives, biological psychiatrists stayed the course, believing either that subsequent generations of medication would have fewer side effects[364] or that since hyperactivity not only affected the child, but his family, classroom, and community, the side effects, which primarily affected the individual in question and not the people around him, were worth tolerating.[365] In this way, the biological approach

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Syndrome in Children," *American Journal of Psychiatry*, Vol. 121 (1964/1965), 389.

[361] Ritalin's chemical structure was believed to be in between that of the milder stimulant, caffeine, and that of the powerful amphetamine Benzedrine. Frederic T. Zimmerman and Bessie B Buregemeister, "Action of Methyl-Phenidylacetate (Ritalin) and Reserpine in Behavior Disorders of Children and Adults," *American Journal of Psychiatry*, Vol. 115 (1958/1959), 323.

[362] Schnackenberg, "Caffeine as a Substitute," *American Journal of Psychiatry*, 796-798.

[363] Seymour Furman and Anne Feighner, "Video Feedback in Treating Hyperactive Children: A Preliminary Report," *American Journal of Psychiatry*, Vol. 129 (1972), 792.

[364] Some psychiatrists also suggested using growth hormones to counteract stimulant side effects. Joaquim Puig-Antich, Laurence L. Greenhill, Jon Sassin, and Edward J. Sachar, "Growth Hormone, Prolactin and Cortisol Responses and Growth Patterns in Hyperkinetic Children Treated with Dextro-Amphetamine," *Journal of the American Academy of Child Psychiatry*, Vol. 17 (1978), 457.

[365] Joseph A, Barsa, "The Pendulum Swings Back," *American Journal of Psychiatry*, Vol. 131 (1974), 227; Puig-Antich, Greenhill, Sassin, and Sachar, "Growth Hormone, Prolactin and Cortisol Responses," *Journal of the American Academy of Child Psychiatry*, 472.

to hyperactivity mirrored other approaches to disease in the United States that valued community well being over individual rights.[366]

Unlike its psychoanalytic and social psychiatric rivals, the way in which biological psychiatrists approached hyperactivity diluted the criticisms of its opponents. Specifically, biological psychiatrists did not describe their field as a finished product, as did social psychiatrists and psychoanalysts, but instead as a work in progress. As such, biological psychiatrists viewed the research they conducted on hyperactivity in progressive or teleological terms. In other words, they were confident that, as their field progressed, research results would build on each other until nagging problems like etiological confusion and alarming side effects were solved and a complete and permanent theory of the disorder was formulated.[367] The path to understanding hyperactivity, like that of smallpox, polio, or even cancer, might be long and arduous, but it was also straight and grounded in biological theory. Furthermore, there was no doubt in the minds of biological psychiatrists that the road they were on was the correct one and would inevitably lead to the answers they desired. More importantly, the American public, increasingly exposed to medical marvels like organ transplantation, wonder drugs, and open heart surgery, similarly developed a burgeoning faith in the ultimate triumph of biological medicine over disease.[368] With this millenarian medical mentality, it became

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[366] For example, Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health* (Boston: Beacon Press), 1996; Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in America* (Baltimore: Johns Hopkins University Press, 1995); Susan Sontag, *Illness as Metaphor* (New York: Vintage Books, 1979).

[367] Werry, "Psychotropic Drugs in Children," *Journal of the American Academy of Child Psychiatry*, 461.

[368] Some contemporary observers explained the public's enchantment with scientific medicine during the 1970s as a reactionary response to the radical approaches to mental illness put forth during the 1960s. Bursten, "Psychiatry and the Rhetoric of Models," *American Journal of Psychiatry*, 664.

easy for those imbued with a faith in the biological interpretation of disease to absorb patiently the bumps in the road to medical discovery.

In this way, biological psychiatrists shrugged off the aforementioned criticisms about their approach to hyperactivity by arguing that they would eventually overcome these obstacles, so long as they were provided with the necessary time and resources.[369] An excellent example of this optimistic attitude is found in a 1971 article in *The American Journal of Psychiatry* entitled "Psychopharmacology: The Picture Is Not Entirely Rosy" by psychiatrist Jonathan O. Cole. Despite its ostensibly pessimistic theme, the article actually reflected an enthusiastic confidence in the future of psychopharmacology. Although Cole cautioned that there was still a great deal of work to be done, he nonetheless suggested that psychiatric ambitions of wonder drugs, magic bullets, and miracle pills would be realized in the future.[370] Similarly, biological psychiatry filled its practitioners and the American public with hopes and dreams of eventual medical triumphs over mental illness. Such a promised legacy effectively neutralized the grievances of biological psychiatry's rival fields that appeared petty in contrast.

Despite the fact that biological psychiatrists like Cole established their field as a highly functioning work in progress, others were careful to reinforce the idea that their work on the disorder was in the early stages of development. When Camilla Anderson's *Society Pays: The High Cost of Minimal Brain Damage in America* came out in 1973,

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[369] Klaus K. Minde and Gabrielle C. Weiss, "The Assessment of Drug Effects in Children as Compared to Adults," *Journal of the American Academy of Child Psychiatry*, Vol. 9 (1970), 131.
[370] Jonathan O. Cole, "Psychopharmacology: The Picture Is Not Entirely Rosy," *American Journal of Psychiatry*, Vol. 127 (1971), 225.

prominent hyperactivity researcher and biological psychiatrist Paul H. Wender gave it a negative review because of its overly bold and conclusive statements about the genetic and neurological basis of minimal brain damage.[371] Biological psychiatrists did not want to fall into the same trap as that of their disciplinary rivals whose rigid, definitive theories were difficult to defend.

Indeed, the conslusive nature of the social psychiatric and psychoanalytic theories of mental illness acted like a glass ceiling for both fields. Social psychiatrists and psychoanalysts stressed that they had already found the answers to mental illness for which biological psychiatrist were searching. However, this claim meant that, unlike biological psychiatry, neither field could brush off serious criticisms of their theories by stating that these obstacles would become irrelevant in the near future. Psychoanalysts and social psychiatrists had to defend their theories based on present realities, rather than promised outcomes.

That physicians and the American public in 1980 understood hyperactivity as a physiological disorder best treated with stimulants is due to the teleological, fluid, and conservative nature of biological psychiatry and its simple, inexpensive, and seemingly effective solution to the disorder, especially when compared to psychoanalytic and social psychiatric strategies. The publication of *DSM-III* in 1980 enshrined the biological interpretation of the disorder in the minds of psychiatrists, but also other physicians, psychologists, teachers, and parents. The consolidation of opinion on hyperactivity

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[371] Although not mentioned in the review, Wender may have also been annoyed by the fact that although Anderson stressed the genetic etiology of hyperactivity, she used the term minimal brain "damage," a term that highlighted brain injury as the primary cause of the condition. Paul H. Wender, Review of *Society Pays: The High Cost of Minimal Brain Damage in America* by Camilla Anderson, *American Journal of*

(termed the familiar Attention Deficit Disorder by *DSM-III*) led to a second and even greater explosion in the number of diagnoses during the 1980s and 1990s.[372] Social and psychoanalytic approaches to hyperactivity and other psychiatric conditions faded away, leaving a biological brand of psychiatry that was one-dimensional, reductionist, and less humanistic than previous approaches.

Psychiatry, Vol. 130 (1973), 726.
[372] Ingersoll, *Daredevils and Daydreamers*, 19-20.

Conclusion

The history of ADHD reveals a number of crucial drawbacks regarding the alleged psychiatric progress that has emerged with the biological revolution in psychiatry. The first problem, which hearkens back to Kennedy's grand scheme for American psychiatry, amounts to a failed opportunity for psychiatry to become a rich source of theoretical and practical knowledge about how to understand and improve human behaviour and the human experience in meaningful ways. Psychiatry's evolution resulted in the hegemony of biological psychiatry within the profession and led to the existence of an underlying assumption that such psychiatric supremacy was healthy. But in the case of ADHD, the dominance of biological psychiatry overshadowed the very inadequacy of the field's approach to fully dealing with or even understanding the complexity of ADHD. Specifically, stimulant therapy of ADHD addresses only one small, physiological aspect of a problem that consists of social, economic, political, and educational dimensions. This is certainly not to say either that stimulants have not helped millions of people deal with the ADHD or that it would have been better for social or psychoanalytical psychiatry to have achieved biological psychiatry's dominance. Each field's approach to mental illness, as exemplified by the story of hyperactivity, was riddled with serious weaknesses and, on its own, would not have sufficiently addressed the problem. However, each field also had certain strengths that complemented those of its rivals. If the physiological knowledge of biological psychiatry had been supplemented with the psychoanalyst's insight into the complexities of the human psyche and human relationships as well as the social psychiatrist's humanism, egalitarianism, and emphasis on prevention, a much more

comprehensive theory of hyperactivity might have been developed. Unfortunately, the opportunity for such a pluralistic psychiatry disintegrated as the rival factions competed, rather than cooperated with each other, to understand hyperactivity.

The second problem with supposed psychiatric progress relates to the first in that the biological domination of psychiatric understanding has undermined not only other approaches to psychiatry, but the very conception of mental illness itself. According to biological psychiatrists, ADHD is a neurological impairment and little else. But the history of ADHD shows that it is much more than that; it is also a reflection of historical and contemporary views about medicine, education, values, gender, normalcy, appropriate behaviour, and personal freedom. A better understanding of the component parts of ADHD and other mental illnesses not only helps the historian explain how disease is constructed, it also helps all those affected by such disorders realize that their pathology is extremely relative to time, place, and situation. The strictly biological approach to ADHD leaves unanswered questions about why boys are disproportionately diagnosed compared to girls,[373] why certain countries are seemingly immune to the problem,[374] and why the disorder affects individuals in vastly different ways.

Certainly, the work done thus far by social scientists reveals a wide variety of explanations for the disorder's emergence. For example, sociologist Adam Rafalovich has utilized Foucauldian theory to argue that ADHD and all therapeutic interventions to

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[373] Ellen Heptinsall and Eric Taylor, "Sex Differences and their Significance," in Seija Sandberg (ed.) *Hyperactivity and Attention Disorders of Childhood*, (Second Edition; Cambridge: Cambridge University Press, 2002), 99.

[374] Ernest S. L. Luk, Patrick W. L. Leung, and Ting-Pong Ho, "Cross-Cultural/Ethnic Aspects of Childhood Hyperactivity," in Seija Sandberg (ed.) *Hyperactivity and Attention Disorders of Childhood* (Second Edition; Cambridge: Cambridge University Press, 2002), 65.

treat it amount to the social control and manipulation of children.[375] In contrast sociologists Peter Conrad and Deborah Potter, as well as anthropologist Andrew Lakoff, have stressed the importance of individual agency and personal choice in the popularization of ADHD.[376] For Conrad and Potter, the collective action and individual agency represented by advocacy groups such as CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder) has been a larger factor in the rise of the disorder than "medical imperialism," or top down medical intervention.[377] Lakoff adds that since parents are most often the first identifiers of ADHD symptoms in their children, social control plays a small role.[378] Still others, such as sociologists Doris Marian Hamner and Claudia Malacrida have acknowledged both factors, stressing the role of conforming institutions like psychiatry and the school system, but also the agency of individuals in understanding how ADHD affects children and their families.[379] Although institutions and society relay a message to parents that their child's behaviour is abnormal and should be altered, parents negotiate their own interpretation of this message and synthesize their own understanding of and reaction to the disorder.

What is valuable and exciting about this work and subsequent sociological, anthropological, and, especially, historical research, is that it encourages debate,

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[375] Adam Rafalovich, "The Conceptual History of Attention Deficit-Hyperactivity Disorder: Idiocy, Imbecility, Encephalitis, and the Child Deviant, 1877-1929," *Deviant Behavior*, Vol. 22, (2001), 93-115; Adam Rafalovich, "Disciplining Domesticity: Framing the ADHD Parent and Child," *Sociological Quarterly*, Vol. 42, No. 3, (2001), 373-393.

[376] Peter Conrad and Deborah Potter, "From Hyperactive Children to ADHD Adults: Observations o the Expansion of Medical Categories," *Social Problems*, Vol. 47, No. 4, (2000), 560; Andrew Lakoff, "Adaptive Will: The Evolution of Attention Deficit Disorder," *Journal of the History of the Behavioral Sciences*, Vol. 36, No. 2 (2000), 149-169.

[377] Conrad and Potter, "From Hyperactive Children to ADHD Adults," *Social Problems*, 560.

[378] Lakoff, "Adaptive," *Behavioral*, 165.

[379] Hamner, "Pathologizing Behaviors, 129; Claudia Ann Malacrida, "Talking Attention Deficit

discussion, and careful examination of all the dimensions of ADHD. Ideally, such research will encourage children, youth, and adults diagnosed with ADHD, as well as their friends and family, to question similarly their own diagnoses. It will encourage them to analyze carefully, and to think in plain terms about what they have really been diagnosed with. Were other factors, including, but not limited to, societal or familial expectations, socio-economic ills, or instances of educational poverty, considered? If so, do these considerations divulge other ways of dealing with or understanding what is really meant by such a diagnosis of pathology? While the history of ADHD provides an instructive and fascinating glimpse into the social, political, and cultural world in which the disorder emerged, it also reveals for the historian, and, more importantly, those most affected by ADHD, that society, not neurology, has been the disorder's indispensable feature.

Similarly, if psychiatry has "progressed" since its most recent biological revolution, then it has done so, as it has during other periods, at the expense of the patient. ADHD and other disorders have become conditions of the brain, rather than that of the mind. Reflective of this transition, human behaviours, interactions, emotions, and thoughts have been reduced to an exceedingly complex, but essentially characterless and soulless series of correct or flawed firings of neurons. Stimulant therapy merely tweaks the neurological engine that runs the body. All patients, moreover, are considered to be homogeneous entities and are expected to behave according to an increasingly narrow set of guidelines. The intricacies of what it means to be a unique human being are forsaken and forgotten at the expense of a hermetically sealed biological theory. The problem with

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(Hyperactivity) Disorder: Mothers, Discourse, and Power," PhD Dissertation University of Alberta, 2001.

this way of conducting psychiatry is that most people do not fit into such neat packages. The same characteristics that signify a disabling ADHD for an individual in one setting may exist as positive attributes in another. This raises the question of what should be changed in order to help a person deal with troublesome ADHD characteristics: the individual or the environment in which he or she exists? When ADHD is considered in this way, a person dealing with the disorder is presented with many more ways in which to adapt to his or her circumstances and, therefore, live his or her life in the manner he or she chooses.

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